CHICAGO WOMEN'S HEALTH GROUP

211 East Chicago Ave, Suite 1200
Chicago Illinois 60611
Phone: 312-943-0282
Fax: 312-943-0284

To our patients,

We value you and your time and want to be able to provide you with the highest quality care. Because of the nature of our practice, we are sometimes required to be away from the office at the hospital for surgeries or deliveries. Because our hospital responsibilities are sometimes unexpected, we have 4 mid-level providers to accommodate our patients who are scheduled in the office. We have two physical assistants and two nurse practitioners who have Masters Degrees and are board certified to practice medicine. We have specifically chosen these individuals and trained them to manage your care in our absence.

If your doctor is not available to see you in the office, we will attempt to contact you prior to your arrival at the office to give you the option to reschedule or see one of our nurse practitioners or physician assistants. If we are not able to reach you, you will be given those options at the front desk. You are always welcome to reschedule if you prefer o see your primary physician. If you do choose to see a PA or NP, you can be assured that you will receive high quality care and that your physician will be updated of any issues. Your physician or a covering physician is available for consults in-person or by phone if necessary and the physicians and mid-level providers have an excellent working relationship. We appreciate your trust and would welcome any feedback that you have regarding your experience in our office.

Thank you for your confidence,

Dr. Kelsey
Dr. Bonner
Dr. Clinton
Dr. Dipasquale
Dr. Mulchandani
Dr. Onia

CHICAGO WOMEN'S HEALTH GROUP

DATE__________________

Please print clearly

PATIENT INFORMATION

Last Name **First** **Middle** **Nickname**

Street Address **Apt #**

City **State** **Zip**

M F

Home Phone **Cell Phone** **Date of Birth** **Sex**

Social Security No. **Email Address**

Employer **Occupation** **Work Phone**

Where would you like to be contacted with results? **May we leave a confidential message?**

Spouse's Name Occupation Telephone Number

Emergency Contact **Relationship** **Emergency contact Number**

Pharmacy Information- To electronically file prescriptions

Store Phone Number

Address City State Zip

Student/Responsible Party Information

Responsible
Party:____

Last First

Address City State Zip

Home Phone Cell Phone

Signature of responsible party: X____

Referred to this physician by: ____

PATIENT QUESTIONNAIRE

Name ______________________________ Date ______________

Please help us to provide the best health care for you by completing this short questionnaire.

	Circle one		If yes, please specify.
Have you changed your occupation?	Yes	No	
Do you have any problems at home?	Yes	No	
Has there been any change in your relationship with your husband, partner, or boyfriend?	Yes	No	
Has there been a change in your periods?	Yes	No	
Date of your last period?			
Do you use a method of contraception?	Yes	No	Do you use it regularly? Are you/your partner satisfied with this method?
If yes, what type? pills IUD diaphragm condoms natural/rhythm sponge spermicide other ______			
Do you want any information about birth control?	Yes	No	
Date of your last Pap test?			
Do you have any questions about safer sex?	Yes	No	
Do you smoke cigarettes?	Yes	No	How many per day?
Do you use street drugs?	Yes	No	
Do you use alcohol?	Yes	No	How often? How much?
Have you ever felt the need to cut down on your drinking?	Yes	No	
Are you exercising?	Yes	No	How often? What type?
Have you had any illnesses?	Yes	No	
Have you seen any of your other doctors recently?	Yes	No	
Are you taking any medicines now?	Yes	No	
Have you ever had a cholesterol test?	Yes	No	When?

Please answer if you are over 39:

Date of your last mammogram? ______________

Date of your last stool test? ______________

What brings you to our office today?

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____

Do you have any questions, problems, or concerns that you would like to discuss with us today?

____

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RESPONSIBILITY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay the deductible, co-insurance, co-pay and any other balances not paid by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

Insurance Type: Medicare ( ) HMO ( ) PPO ( ) POS ( ) EPO ( ) OTHER ( )

Primary Company: ____________________ Address ____________________ Effective Date ______

Policy Number ____________________ Group # ______________ Phone # ______________

Subscriber ____________________ Relationship to subscriber ____________________

D.O.B ____________________ SSN _______-_____-_________

Secondary Company ____________________ Address ____________________

Policy # ____________________ Group # ______________ Phone # ______________

Subscriber ____________________ Relationship to Subscriber ____________________

YOUR INSURANCE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENTS OF SERVICE RENDERED

The Non-Medicare Patient

I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Chicago Women's Health Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

The Medicare Patient

I request that payment of authorized Medicare benefits to be made to me on my behalf to Chicago Women's Health Group for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient X ____________________ Responsible Party X ____________________

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SUITE 1200
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The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

The paragraph at the bottom of this page is an addendum to the notice of our Privacy Practices. (See Notice of Privacy Practices on next page) Some exciting new changes in the electronic health record system across the physician practices at Northwestern are taking place. The eventual plan is for all physician practices to be able to access all their patients' electronic records within the Northwestern physician system. (i.e. your internist will be able to look into your lab results at your gynecologist's office and see that you had a pap and it was normal)

Please read the paragraph below. If you wish your information to be accessible to your other doctors at Northwestern, please opt in to this program. Please feel free to ask should you have any questions.

This practice is using an electronic health record information system (the "EHR System"), in coordination with Northwestern Memorial Hospital (NMH). The collection and use of all information through the EHR System is primarily for the purpose of treatment of patients by NMH, this medical practice and other medical practices in a clinically integrated care setting. The information collected through the EHR System may include information regarding my diagnosis and treatment for mental health, developmental disabilities, HIV, AIDS, drug and alcohol abuse, genetic testing and counseling. The EHR System is not equipped to segregate such data from my other health information. All information collected through the EHR System may also be shared with, and used by, NMH and certain other hospitals, academic institutions, and health care providers that perform medical or research activities on NMH's campus or otherwise in conjunction with NMH (including, but not limited to Northwestern University, the Feinberg School of Medicine, Children's Memorial Hospital, and the Rehabilitation Institute of Chicago) for the following related activities, which may include: (a) conducting peer review; (b) promoting quality assurance; (c) mortality and morbidity analysis; (d) conduction utilization review; (e) evaluating and improving the quality of care; (f) promoting and maintaining professional standards; (g) examining costs and maintaining cost control; (h) conducting medical audits; (i) assisting the medical staff membership and credentialing process; (j) performing date quality management; (k) improving the efficiency and effectiveness of healthcare; (l) conducting research; (m) extracting data from the EHR System and any related database for any of the above activities.

Please mark the appropriate circle and PRINT, SIGN, and DATE.

O I have read the privacy practices and consent to sharing my information with Northwestern providers

X________________________________ ________________

Print & Sign *Date*

O I have read the privacy practices and DO NOT consent to sharing my information with Northwestern providers

X________________________________ ________________

Print & Sign *Date*