Affinity
WOMEN'S HEALTH CARE

Dr. Susan Catt, OB/GYN
Heather Porto, CNM
Amy Pheiffer, APN
Shannon Graves, APN

Thank you for choosing Affinity Women's Health Care! Enclosed in this envelope is the paperwork needed to be completed and brought to your appointment. **We ask that you arrive for your new patient appointment 30 minutes early with your paperwork completed.** If your paperwork is not complete, and this delays us from being able to start your appointment on time, you may be asked to reschedule your appointment. Our goal is to stay on time for all the appointments we have scheduled each day and respect the time of both our patients and providers.

Along with your completed paperwork, please make sure to bring the following items to your appointment. Failure to have any of the listed items below may cause your appointment to be rescheduled:

- Insurance card – failure to produce card will result in a self-pay or rescheduled appt.
- Photo ID
- Medication list
- Medical records (if you have not already had them sent) – **Fax 309-966-3863**
- Co-payment (all co-pays that are applicable will be collected at time of service) Inability to pay your co-pay at time of service may require your appointment to be cancelled.

If at the time of your appointment you would like to have a female standby with the provider during your exam, please notify the staff member that takes you to your room.

Thank you for your cooperation and we look forward to meeting you!

5401 N. Knoxville, Peoria 61614 // Suite 304

- **Drive around to the back of the Proctor Professional Building on the left hand side, near the playground and parking deck.**
- **Enter through "Entrance 1" labeled on the awning**
- **Take the elevator to the third floor. We are immediately to the right when you exit.**

Please call if you have any difficulty finding our office. 309-966-3862 Thank you!

Appointment date & time: _____

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DATE: _____

Name: _____
First MI Last Maiden

Reason for Visit: _____ Date of Birth: _____ Age: _____

Primary Care Provider: _____

I identify with the following pronoun: ☐ She/Her ☐ He/Him ☐ They/Them

PATIENT MEDICAL HISTORY (Please mark Y if applicable to you)

History	Y	History	Y	History	Y	History	Y
Abnormal Pap Smears	☐	Depression	☐	Hypertension	☐	Sickle Cell Disease/Trait	☐
Allergic Rhinitis	☐	Diabetes, Type 1	☐	Infertility	☐	Skin Disease	☐
Anemia/Hematologic	☐	Diabetes, Type 2	☐	Intestinal Disease	☐	Stomach Problems	☐
Anxiety	☐	Frequent UTI's	☐	Kidney Disease	☐	Stroke	☐
Arthritis	☐	Gestational Diabetes	☐	Liver Disease	☐	Thyroid Disorder	☐
Asthma/Pulmonary	☐	Heart Disease	☐	Migraines/Headaches	☐	Trauma	☐
Autoimmune Disorder	☐	Hepatitis	☐	Mitral Valve Prolapse	☐	Urinary Incontinence	☐
Blood Transfusion	☐	Herpes	☐	Neurological Disorder	☐	Uterine Abnormalities	☐
Bowel Disorder	☐	High Blood Pressure	☐	Pulmonary Embolism	☐	Varicosities/DVT/ Blood clot	☐
Breast Disorder	☐	High Cholesterol	☐	Psychiatric Disorder	☐	Yeast	☐
Chlamydia/Gonorrhea/Trich	☐	HIV/AIDS	☐	(Rh) Sensitized	☐		
Complication w/ Anesthesia	☐	HPV	☐	Seizures	☐		

EXPOSURE AND INFECTION HISTORY

Exposure/Infection History	Y	Exposure/Infection History	Y
Partner has history of HIV	Y☐	Rash or viral illness since last menstrual period (LMP)	Y☐
Patient or Partner has history of Genital Herpes	Y☐	History of Sexually Transmitted Disease (STD)	Y☐
Exposure to TB	Y☐	Other exposure or history of infection	Y☐

Surgical History (Please provide Month/Year for all that apply):

____/____ Appendectomy	____/____ Wisdom Teeth	____/____ Lithotripsy
____/____ Tonsillectomy	____/____ Orthopedic Surgery	____/____ Lung
____/____ Gallbladder	____/____ Brain Surgery	
____/____ Bladder	____/____ Bowel	

Additional Surgeries: _____

Previous Gyne Surgical History (Please provide Month/Year for all that apply):

____/____ Colposcopy	____/____ Bilateral Tubal Ligation	____/____ Ablation
____/____ Cryotherapy	____/____ Breast Augmentation	____/____ LEEP
____/____ Hysterectomy	____/____ Cesarean Section	____/____ D&C
____/____ Cone Biopsy	____/____ Breast Biopsy (Left / Right)	____/____ Essure
____/____ Removal of one or both ovaries		

Additional Surgeries: _____

Gynecology History (Please complete all questions that apply):

How old were you when you had your first menstrual period? _____ Menopause? _____

If you are currently having periods, what was the date of the first day of your last period? _____

Do your periods occur regularly? _____ How long do your periods typically last? _____

How do you consider your menstrual flow? Heavy Moderate Light

How do you consider your menstrual pain? Severe Moderate Mild

Do you perform self-breast exams?_____

Are you currently sexually active? _____

If yes, are you sexually active with Men, Women, or Both? _____

If so, how many partners have you had in the past 12 months? _____

Do you experience any pain or bleeding with intercourse? _____

What is your current method(s) of contraception? _____

Past method(s) of contraception? Any problems? _____

Obstetrical History (Please complete all questions that apply):

Total Pregnancies: _____ Full Term Deliveries: _____ Preterm Deliveries: _____ Elective Abortions: _____

Miscarriages: _____ Ectopic Births: _____ Multiple Births: _____ Living Children: _____

Please include date(s) of miscarriage(s):

_____

Delivery Date	Weeks Preg	Length of Labor	Birth Wt	Sex M or F	Hospital	Type of Delivery
1.			_____ lbs _____ oz			☐ Vaginal ☐ C-Section
2.			_____ lbs _____ oz			☐ Vaginal ☐ C-Section
3.			_____ lbs _____ oz			☐ Vaginal ☐ C-Section
4.			_____ lbs _____ oz			☐ Vaginal ☐ C-Section
5.			_____ lbs _____ oz			☐ Vaginal ☐ C-Section
6.			_____ lbs _____ oz			☐ Vaginal ☐ C-Section

Please List Any Complications (miscarriages, etc…) with any pregnancies - PLEASE PROVIDE DATE(S) OF MISCARRIAGE(S):

_____

_____

_____

Family Medical History (Please list Mother / Father / Sister / Brother / Maternal or Paternal Grandparents):

_____ Ovarian Cancer _____ Heart Disease _____ Diabetes

_____ Uterine Cancer _____ Stroke _____ Osteoporosis/Fractures

_____ Breast Cancer _____ Hypertension _____ Blood Clotting Disorders

Additional Diseases or Cancer Types: _____

Social History:

Do you smoke:	Yes	No	# of cigarettes per day:	
Do you drink alcohol?	Yes	No	# of drinks:	Frequency:
Do you use recreational drugs?	Yes	No	Type:	Frequency:
Are you employed?	Yes	No	If yes, where?	
What is your marital status?				
Who do you live with?				
Do you exercise regularly?	Yes	No	Type of exercise:	Frequency:
Do you consume caffeine regularly?	Yes	No	# of drinks per day:	Coffee / Tea / Soda / Other:
Do you wear seat belts regularly?	Yes	No		

Routine Health Screening History (Please provide Month / Year for all that apply):

____/____ Lipids Testing	Normal	Abnormal	_____
____/____ Thyroid Testing	Normal	Abnormal	_____
____/____ Other Blood Work	Normal	Abnormal	_____
____/____ Most Recent Pap Smear	Normal	Abnormal	LSIL HSIL ASCUS ASCUS-H AGUS Unknown
____/____ Previous Abnormal Pap Smear		Abnormal	LSIL HSIL ASCUS ASCUS-H AGUS Unknown
____/____ Gonorrhea / Chlamydia	Negative	Positive	_____
____/____ RPR (Syphilis) Testing	Negative	Positive	_____
____/____ HSV (Herpes) Culture	Negative	Positive	_____
____/____ HSV (Herpes) Blood Testing	Negative	Positive	_____
____/____ HIV Testing	Negative	Positive	_____
____/____ Mammogram	Normal	Abnormal	_____
____/____ Bone Densitometry	Normal	Abnormal	_____
____/____ Colonoscopy	Normal	Abnormal	_____

Additional Health Screening:

Immunization History (Please provide all that apply):

____/____ Flu Vaccine ____/____ HPV Vaccine

____/____ Pneumonia Vaccine ____/____ Zoster Vaccine

Additional Immunizations: _____

Preferred Pharmacy:_____ _____
Name Location

Please list all the medications and dosages that you are currently taking (prescription, supplements, and over-the-counter):

_____

_____

Please list all medical allergies and symptoms (medicine, latex, etc):

_____

_____

Please list all other allergies and symptoms (environmental, food, etc):

_____

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Patient Name: _____ DOB: _____ Date:_____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
a.	Little interest or pleasure in doing things	☐	☐	☐	☐
b.	Feeling down, depressed, or hopeless	☐	☐	☐	☐
c.	Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d.	Feeling tired or having lack of energy	☐	☐	☐	☐
e.	Poor Appetite or Overeating	☐	☐	☐	☐
f.	Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h.	Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i.	Thoughts that you would be better off dead or of hurting yourself in any way	☐	☐	☐	☐

2. **If you checked off *<u>any</u>* problem on this questionnaire, how *<u>difficult</u>* have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult at all	Somewhat difficult	Very Difficult	Extremely difficult
☐	☐	☐	☐

Total # symptoms: _____

FINANCIAL POLICY AND AGREEMENT

Patient Name: _____

Date of Birth: _____

We here at Affinity Women's Health Care, S.C., know that choosing a physician is a very important decision and we thank you for choosing our office. Please take a minute to carefully read this overview of some of our financial policies.

INFORMATION REGARDING INSURANCE COVERAGE

You inform yourself and understand the details of your health insurance coverage and fulfill any associated requirements (pre-certification, obtaining referrals, providing information regarding pre-existing conditions, etc). It is also your responsibility to provide our office with all required information regarding your health insurance coverage. It is important that you promptly notify us if there are any changes to your insurance information. If any complications arise during the billing process, you have an obligation to promptly provide assistance and information to our billing staff and if you fail to timely provide any information or assistance then we have the right to not submit the claim to your insurance company and you will be fully responsible to pay us for the balance. In the case of an IUD, a $100.00 non-refundable deposit is required prior to the device being ordered. This deposit will be applied to any charges remaining from this appointment or any unpaid balances on the account of any type.

NON-PARTICIPATING PROVIDER OR NON-COVERED BENEFITS

If we do not participate with your health insurance carrier, or if the services provided are not covered under your particular health plan, then you are responsible for paying for all services at the time of service. If you would like us to do so, we can (upon your request and full payment) provide a statement for your records and/or reimbursement purposes.

PARTICIPATING PROVIDER AND COVERED BENEFITS

If we participate with your health insurance carrier and the services sought are covered services, we will directly bill your health insurance carrier. Under your plan, you may be responsible for paying certain amounts (co-payments, deductibles, and fees for non-covered services), which are due at the time of service.

TYPES OF PAYMENT

OUR OFFICE ACCEPTS CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS.

COLLECTION OF OUTSTANDING BALANCES

All outstanding balances shall be due within 30 days. All past due balances are due in their entirety, prior to or at the time of your visit. Balances that are 30+ days old will be assessed a finance charge of 18% per annum (1.5% per month) from the original due date that will accrue monthly until paid. Balances that remain outstanding for a period of 90 days or more may be referred to a collection agency or attorney's office. If your account is referred to an outside attorney, you will be responsible for paying all reasonable attorneys' fees and court costs, which are in addition to your outstanding balance. You will be charged $35.00 for any check returned from your bank for any reason. If we choose to resubmit the check additional times, you will be charged an additional $35.00 each time it is returned. Failure to pay any charges described herein shall result in a refusal of non-emergency services until the full balance is paid off or any payment plan agreed to in a signed writing by both parties.

MISSED APPOINTMENTS

It is important that you appear for all scheduled appointments. As a courtesy, an appointment reminder will be initiated one to two days before the scheduled appointment. If speaking to you is not possible for any reason, we will attempt to leave a voicemail. Failure to cancel your appointment without giving more than 24 hours' notice deprives other patients of an opportunity to visit our office. A records fee of $25 will be charged if you fail to appear for any scheduled appointment. We recognize that there may be circumstances which may not permit you to give a 24 hour notice and such circumstances are exceptional and shall be considered on a case-by-case basis.

RETENTION OF FILE

Affinity Women's Health Care, S.C. agrees to assert a diligent effort, subject to casualties beyond the control of Affinity Women's Health Care, S.C. to retain the files relative to this relationship for a period of three (3) years after the conclusion of each service, and during such time to afford Patient reasonable access to such files.

COMPLETE INTEGRATION BINDING UPON ALL PARTIES

This Agreement contains the entire agreement between the Patient and Affinity Women's Health Care, S.C., regarding this matter and fees, charges, and expenses to be paid relative thereto. This agreement shall not be modified except by written agreement signed by Patient and Affinity Women's Health Care, S.C. This agreement shall be binding upon the Patient and Affinity Women's Health Care, S.C., and their heirs, executors, legal representatives, successors and assigns.

ACKNOWLEDGMENT

Patient further acknowledges that Patient has signed this agreement after having fully read and reviewed it. Patient acknowledges that Patient understands the agreement and has been presented by Affinity Women's Health Care, S.C., and support staff with an opportunity to read and review it at the time of signature and to ask such questions as would enable Patient to fully understand this agreement. Patient further acknowledges that upon the signing and execution of the original of this agreement Patient was given a copy thereof and that Patient acknowledges receipt of such copy.

By signing below, the patient or responsible party acknowledges that he/she has read and understands the Financial Policy of Affinity Women's Health Care, S.C. and agrees to be bound by the terms and conditions set forth therein.

_____

Signature of Patient or Responsible Party — Address of Responsible Party

_____

Print Name of Patient or Responsible Party — Phone Number of Responsible Party

_____ — _____

Date — Signature of Parent/Guardian of Minor Patient

HIPAA

I, _____ hereby acknowledge receipt of the Physician's Notice of Privacy Practices. This notice provides detailed information about how the practice may use my confidential information.

I understand that the physician has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any revised notice will be provided to me or made available in the office at my request. I also understand that my protected health information may be requested by my insurance company in order to process my medical claims on my behalf.

In order to ensure patient privacy and confidentiality, our office will not release information to friends or family members without your written consent. Please list any family member or other persons who may contact our office on your behalf. This consent will allow us to inform them about your general medical conditions.

Name	Relationship	Contact Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Can appointment reminders or messages asking you to call our office be left on the phone number you have provided to our office? Yes No
Can we contact your place of employment to inform you of your test results or other health care information? Yes No

_____
Printed Name

_____ Date _____
Signature

PATIENT INFORMATION

Patient Name _____
Last First MI Maiden Name

Date of Birth _____/_____/_____ Age _____ SS# _____/_____/_____

Address _____
Street City State Zip

Home Phone (_____)_____ Cell (_____)_____

E-Mail Address_____ Preference of appointment notification: Text ___ Phone Call ___ Email ___ (Please Check)

Place of Employment _____ Work # (_____)_____

Preferred Hospital: ☐ OSF ☐ Carle Health

Preferred Pharmacy (please list name, street, and city): _____

Race/Ethnic background: Please circle all that apply
Caucasian African American Hispanic/ Latino Middle Eastern Asian Native American Hawaiian/ Pacific Islander Decline

Partner/Insured Party's Information (If Different From the Patient's)

Name _____ DOB _____/_____/_____ SS# _____/_____/_____

Relationship _____ Phone (_____)_____ Employer _____

EMERGENCY CONTACT

Name _____ Relationship _____

Phone (_____)_____ DOB _____/_____/_____

INSURANCE INFORMATION (This section must have all applicable lines completed)

Primary Ins. Co. _____ Group # _____ Policy # _____

Insured: ☐ Self ☐ Spouse ☐ Other _____ (List Relationship)

Secondary Ins. Co. _____ Group # _____ Policy # _____

Insured: ☐ Self ☐ Spouse ☐ Other _____ (List Relationship)

I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information requested with regard to processing my claim. I certify that information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

Signature: _____ **Date:** _____

Pharmacy Benefit Managers

We are pleased to offer a new feature to our patients. We can now automatically obtain your prescription history from Pharmacy Benefit Managers (PBM) via Surescript and download the prescription information into your electronic medical chart. It will make it easier for you to share your medical history with us and give us the ability to provide you with better, more efficient quality care.

In order to take advantage of this program, we will require your permission. Please complete as indicated below and return the form to the receptionist.

_____ I GIVE permission to Affinity Women's Health Care, SC to obtain my prescription history directly from PBM.

_____ I DO NOT GIVE permission to Affinity Women's Health Care, SC to obtain my prescription history from PBM.

Printed Name: _____

Signature: _____

Date: _____

GOVERNMENT ASSISTANCE & MEDICARE POLICY

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES & MEDICARE

Affinity Women's Health Care has a policy of providing care to patients who are covered by government assistance programs such as The Illinois Medical Assistance Program (MEDICAID), including All Kids and Healthy kids and any form of Medicare. However, our office must limit the number of Medicaid and Medicare patients to whom we provide services. Our office is **NO LONGER ACCEPTING** any Illinois Department of Public Aid coverage as **Primary or Secondary**. We are also **NO LONGER ACCEPTING** any **new** patients with Medicare policies of any type. Current patients who age into a Medicare policy will be accepted. This policy will be effective January 2, 2018. If you choose to transfer to another physician based on insurance coverage, Affinity Women's Health Care will transfer all medical records without charge.

AUTHORIZATION: I HAVE READ THE ABOVE POLICY FOR AFFINITY WOMEN'S HEALTH CARE AND AGREE TO COMPLY WITH THE TERMS OF THE GOVERNMENT ASSISTANCE POLICY.

PLEASE SIGN EVEN IF THIS DOES NOT APPLY TO YOUR CURRENT INSURANCE SITUATION.

NAME PRINT: _____

NAME SIGNATURE: _____

DOB: _____

TODAY'S DATE: _____