



Thank you for choosing Affinity Women’s Health Care. We are happy to be able to take care of your obstetric and gynecological needs.

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
- Medication list
- Photo ID (we will request a current picture at the time of check in for your appointment)
- 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

Please drive around to the back of the Proctor Professional Building – past the playground, next to the parking deck.

You will need to come in through “Entrance 1” – labeled with a blue square on the awning. The elevator is directly through the doors. We are on the third floor to the right of the elevator.

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

Appointment date & time: _____

Dr. Susan Catt

Dara Wagner, APN

Lindsey Fritz, APN

Heather Porto, CNM

Carolyn Calhoun, CNM



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 Medicare policies of any type. This policy will be effective January 2, 2018. If you choose to transfer to another physician based on insurance coverage, Affinity Women's HealthCare 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

NAME PRINT: _____

NAME SIGNATURE: _____

DOB: _____

TODAY'S DATE: _____



DATE: _____

Name: _____
 First MI Last Maiden

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

Primary Care Provider: _____

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

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

EXPOSURE AND INFECTION HISTORY

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

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

<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Wisdom Teeth	<input type="checkbox"/> Lithotripsy
<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Orthopedic Surgery	<input type="checkbox"/> Lung
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Brain Surgery	
<input type="checkbox"/> Bladder	<input type="checkbox"/> Bowel	

Additional Surgeries: _____

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

<input type="checkbox"/> Colposcopy	<input type="checkbox"/> Bilateral Tubal Ligation	<input type="checkbox"/> Ablation
<input type="checkbox"/> Cryotherapy	<input type="checkbox"/> Breast Augmentation	<input type="checkbox"/> LEEP
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Cesarean Section	<input type="checkbox"/> D&C
<input type="checkbox"/> Cone Biopsy	<input type="checkbox"/> Breast Biopsy (Left / Right)	<input type="checkbox"/> Essure
<input type="checkbox"/> 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			<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
2.			_____ lbs _____ oz			<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
3.			_____ lbs _____ oz			<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
4.			_____ lbs _____ oz			<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
5.			_____ lbs _____ oz			<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section
6.			_____ lbs _____ oz			<input type="checkbox"/> Vaginal <input type="checkbox"/> 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):						
<input type="checkbox"/>	Lipids Testing	Normal	Abnormal			
<input type="checkbox"/>	Thyroid Testing	Normal	Abnormal			
<input type="checkbox"/>	Other Blood Work	Normal	Abnormal			
<input type="checkbox"/>	Most Recent Pap Smear	Normal	Abnormal	LSIL	HSIL	ASCUS
<input type="checkbox"/>	Previous Abnormal Pap Smear		Abnormal	ASCUS-H	AGUS	Unknown
<input type="checkbox"/>	Gonorrhea / Chlamydia	Negative	Positive			
<input type="checkbox"/>	RPR (Syphilis) Testing	Negative	Positive			
<input type="checkbox"/>	HSV (Herpes) Culture	Negative	Positive			
<input type="checkbox"/>	HSV (Herpes) Blood Testing	Negative	Positive			
<input type="checkbox"/>	HIV Testing	Negative	Positive			
<input type="checkbox"/>	Mammogram	Normal	Abnormal			
<input type="checkbox"/>	Bone Densitometry	Normal	Abnormal			
<input type="checkbox"/>	Colonoscopy	Normal	Abnormal			
Additional Health Screening: _____						
Immunization History (Please provide all that apply):						
<input type="checkbox"/>	Flu Vaccine	<input type="checkbox"/>	HPV Vaccine			
<input type="checkbox"/>	Pneumonia Vaccine	<input type="checkbox"/>	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):

Patient Name _____

Date of Birth _____ Today's Date _____

Provider seeing today _____

Cancer Family History

For questions 1 through 5 please consider all relatives (listed below) from BOTH your Mother's and Father's side of the family: Father, mother, brothers, sisters, half-siblings, your children, Grandparents, Aunts, Uncles, Nieces, Nephews

- | | |
|---|--------|
| 1) Have you had BREAST cancer (at any age)? | YES NO |
| 2) Have any of the above relatives had BREAST cancer at age 49 OR YOUNGER ? | YES NO |
| 3) Have you or any of the above female relatives had OVARIAN cancer (at any age)? | YES NO |
| 4) Have you or any of the above relatives had COLON or UTERINE cancer at age 50 OR YOUNGER ? | YES NO |
| 5) Have any of the above relatives had PANCREATIC cancer? | YES NO |

For questions 6 through 8 please consider all relatives (listed below) from BOTH your Mother's and Father's side of the family: Father, mother, brothers, sisters, half-siblings, your children, Grandparents, Aunts, Uncles, Nieces, Nephews, Cousins, Great Aunts/Uncles, Great Grandparents

- | | |
|---|--------|
| 6) Have you had THREE or more relatives listed above (can include you) with BREAST, PROSTATE or PANCREATIC cancer on the SAME side of the family? | YES NO |
| 7) Have you had THREE or more relatives (can include you) with any of the following cancers: COLON, UTERINE, OVARIAN , on the SAME side of the family? | YES NO |
| 8) Were any of the relatives with breast cancer MALE ? | YES NO |

Has anyone in your family (including you), that you know of, had hereditary cancer testing (i.e. BRCA mutation or Lynch Syndrome)?			
If YES , WHOM?	APPROX YEAR?	RESULT (POS/NEG)?	YES NO Unsure

PATIENT SIGNATURE _____

OFFICE USE ONLY

Patient appropriate for testing Accepted Declined Undecided

Patient does not meet criteria Date of Test _____



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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having lack of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor Appetite or Overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in any way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. If you checked off any problem on this questionnaire, how difficult 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

Patient Name: _____

Date of Birth: _____

We 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 must be informed of 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 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.

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. If your check is dishonored, you will be required to pay an additional fee of \$35.00, which shall be due immediately.

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 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 a collection agency, you will be responsible for paying a collection charge equal to 40% of your outstanding balance, which is in addition to your outstanding balance. 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.

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 within 24 hours deprives other patients of an opportunity to visit our office. A 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.

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 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



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 #
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Signature

Date _____



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.**

Signature: _____

Date: _____

Patient Name: _____