



**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)
- 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!

**Appointment date & time:** \_\_\_\_\_

**Dr. Catt**

**Lindsey Fritz, APN**

**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):**

<u>    /    </u> Appendectomy	<u>    /    </u> Wisdom Teeth	<u>    /    </u> Lithotripsy
<u>    /    </u> Tonsillectomy	<u>    /    </u> Orthopedic Surgery	<u>    /    </u> Lung
<u>    /    </u> Gallbladder	<u>    /    </u> Brain Surgery	
<u>    /    </u> Bladder	<u>    /    </u> Bowel	

Additional Surgeries: \_\_\_\_\_

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

<u>    /    </u> Colposcopy	<u>    /    </u> Bilateral Tubal Ligation	<u>    /    </u> Ablation
<u>    /    </u> Cryotherapy	<u>    /    </u> Breast Augmentation	<u>    /    </u> LEEP
<u>    /    </u> Hysterectomy	<u>    /    </u> Cesarean Section	<u>    /    </u> D&C
<u>    /    </u> Cone Biopsy	<u>    /    </u> Breast Biopsy (Left / Right)	<u>    /    </u> Essure
<u>    /    </u> 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? \_\_\_\_\_

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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
<input type="checkbox"/>	Previous Abnormal Pap Smear		Abnormal	ASCUS	ASCUS-H
<input type="checkbox"/>	Gonorrhea / Chlamydia	Negative	Positive	AGUS	Unknown
<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):  
 \_\_\_\_\_



## Cancer Family History Questionnaire

Personal Information			
Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know. The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, ovarian, or pancreatic cancer at any age	<input type="checkbox"/> Y <input type="checkbox"/> N		
Colorectal or uterine cancer at 64 or younger	<input type="checkbox"/> Y <input type="checkbox"/> N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> P	
Two breast cancers (bilateral) in one relative at any age	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> P	
Three breast cancers in relatives on the same side of the family at any age	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> P	
Ovarian cancer at any age	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> P	
Pancreatic cancer at any age	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> P	
Male breast cancer at any age	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> P	
Metastatic prostate cancer at any age	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> P	
Colon cancer at 49 or younger	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> P	
Uterine cancer at 49 or younger	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> P	
Ashkenazi Jewish ancestry with breast cancer at any age	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> M <input type="checkbox"/> P	
Do you have a family history of other cancers?	<input type="checkbox"/> Y <input type="checkbox"/> N	List them here:		
Have you or anyone in your family had genetic testing for hereditary cancer?	<input type="checkbox"/> Y <input type="checkbox"/> N	Who?	What gene(s)?	What was the result?

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)	
Patient Signature _____	Date _____
Healthcare Provider Signature _____	Date _____
Office Use Only Patient offered hereditary cancer genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Accepted <input type="checkbox"/> Declined	
If yes, which test? <input type="checkbox"/> BRACAnalysis® with Myriad myRisk® <input type="checkbox"/> Multisite 3 BRACAnalysis® REFLEX to BRACAnalysis® with Myriad myRisk® <input type="checkbox"/> COLARIS <sup>plus</sup> with Myriad myRisk® <input type="checkbox"/> COLARIS AP <sup>plus</sup> with Myriad myRisk® <input type="checkbox"/> Single Site Testing <input type="checkbox"/> Myriad myRisk® Update <input type="checkbox"/> Other: _____	
Follow-up appointment scheduled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of next appointment: _____

MSWHFHC08G 03/19



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 \_\_\_\_\_

**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  UnityPoint

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 # (\_\_\_\_) \_\_\_\_\_

**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: \_\_\_\_\_



**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:** \_\_\_\_\_