Women's Care Group

5851 W. 95th St., STE 400
Oak Lawn, IL 60453
(708) 857-7230
(708) 425-5779 Fax

Foti Chronopoulos, MD FACOG
Tejas Sheth, MD FACOG
Maria Kronlage, DO FACOOG
Sarah Nathan, MD
Mary Bisaga, APN FNP
Rebecca Lawrence, APN WHNP

10762 W. 167th St.
Orland Park, IL 60467
(708) 873-0400
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Welcome to our office and thank you for choosing us as your healthcare providers. Our highly qualified providers and staff are committed to doing everything possible to provide you with excellent care and make your visit to our office pleasant and comfortable. Our hope is that together we develop a partnership to keep you as healthy as possible, no matter what your current state of health.

There are currently six providers in the office: four physicians and two advanced practice nurses. If you are pregnant, we ask that you have appointments with all six providers. Due to the unpredictable nature of obstetrics, any of the physicians may deliver your baby (1 of our physicians is male and 3 are female) or any of our nurse practitioners may see you in the office or at the hospital. Our nursing staff is composed of highly specialized labor and delivery nurses and medical assistants who are a great resource of information. With their experience and knowledge, as well as the guidance of our office policies, they can answer most of your questions. However, if they cannot, they will direct you to one of the providers.

The following guidelines are set up to guarantee patient care and provide the safety and welfare of all patients:

Contacting the Providers for Emergencies- The office phones are active 24 hours/day. In the event of an emergency, please call our office immediately regardless of time, weekend, or holiday. After you page the provider, you should receive a call back within 15 minutes. In the unlikely event that you do not receive a return phone call within 15 minutes, please have us paged again. If you do not receive a phone call within 30 minutes, please go to the emergency room. If you have general questions, or non-emergent concerns after office hours, please feel free to call the office the next business day and our staff will be happy to assist you. If you choose to have the providers paged for non-emergent reasons, there will be a $25.00 service fee processed to your account. We consider any problems in pregnancy an emergency.

Cancellation/No Show/Missed Appointment Fees (Doctor Appointment)- It is very important that you attend every scheduled appointment so that we can provide you with the best possible care. Cancellations and/or changes need to be made at least **24 hours** prior to your appointment time. Failure to do so will result in a $50.00 missed appointment fee. If you miss your appointment due to an emergency, we will waive the fee. This fee is not covered by your insurance.

Cancellation/No Show/Missed Appointment Fees (New Dawn Wellness Group Appointment)- Due to the large block of time and special arrangements, last minute cancellations/no shows will be charged a one hundred dollar ($100) fee. This fee is not covered by your insurance.

Cancellation/No Show/Missed Appointment Fees (Surgery/Procedure Appointment)- Due to the large block of time needed for surgery/procedure, last minute cancellations or no shows can cause problems and added expenses for the office.
If surgery/procedure is not cancelled at least 48 hours in advance you will be charged a two hundred and fifty dollar ($250) fee; this fee is not covered by your insurance.

Physician Cancellation- Unfortunately, physicians may be called out to the office at any given timed due to emergencies or deliveries. We will do our best to notify you if this occurs and you will have the option of reschedule or seeing a nurse practitioner if available.

If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time they are rendered. We accept cash, check, Visa or MasterCard for payments. We will be happy to process any insurance claims for you and we do accept insurance assignment. We will do our very best to accurately ***estimate*** what your insurance company will pay toward normally covered services. Please understand, however, our calculations are strictly an estimate and is no guarantee that your insurance company will reimburse us according to these estimates. Ultimately, your insurance is contracted between you and your insurance carrier. We are not a party to that contract. Any service that is not covered by your insurance company, for whatever reasons, is your financial responsibility.

Returned checks, NSF fees, and balances older than 90 days will be subject to additional collection fees and interest charges of 1.5% per month. **Any attorney or collection fees incurred due to delinquency in payment will be charged to the patient**.

Payment is always due at the time services are rendered. For more extensive procedures, we can provide easy payment options to make these services more affordable.

_____ _____

Signature Date

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☐ By checking this box and signing below, I hereby acknowledge that I have read this document and understand my financial responsibility for services provided for me and other patients whose names I have provided and appear on my account.

Thank you for choosing our office. In order to serve you properly please print all information below. This information is required and will be kept confidential. Failure to fill out information may cause delays in payment from your insurance company, making you responsible for all charges.

My Co Pay for Specialist's is: _____ My preferred Pharmacy is:_____ Located at _____

Name _____ Date of Birth_____

Address_____ Apt # _____ City _____State ____ Zip Code _____

Home Phone # _____ Cell Phone # _____ E-Mail _____

HIPAA: May we leave a detailed message on Home # (Circle One) Yes No
HIPAA: May we leave a detailed message on Cell # (Circle One) Yes No

Marital Status (Circle One) Married Widowed Single Divorced

Social Security # _____-_____-_____Driver's License #_____

Employer Name _____ Employer Phone # _____

Emergency Contact Person_____ Relationship_____ Phone# _____

Whom may we thank for referring you/how did you hear about us? _____

PLEASE LIST HERE IF YOU HAVE A SECONDARY INSURANCE_____
(We do not accept Public Aid as secondary insurance)

Responsible Party-Insurance Holder (Subscriber) Information

☐ **Please check this box if the patient is the insurance subscriber and this information is the same as above.**

Primary Insurance: _____

Name of Insured_____ Relationship to Patient: _____Date of Birth _____

Address_____ Apt # _____ City _____State ____ Zip Code _____

Home Phone # _____ Cell Phone # _____

Social Security # _____-_____-_____ Driver's License #_____

Employer Name _____ Employer Phone # _____

Secondary Insurance : If yes complete the following;

Insurance Company_____

Name of Insured: _____ Relationship to Patient_____ Date of Birth_____

SSN_____-_____-_____ Home Phone #_____ Work Phone#_____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the Doctor, realizing I am responsible to pay any non-covered service.

_____ _____
Signature Date

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ **Home Telephone**

Number _____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐ **Written Communication**

☐ OK to mail to home

☐ OK to email

☐ **Work Telephone**

Number _____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐ **Cellular Telephone**

Number _____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐ OK to text

Release of Medical Information

Please list any person or persons whom we may discuss about your medical information or appointments.

Name	Relationship	Medical Information	Make, change or cancel appointments
		Yes or No	**Yes or No**
		Yes or No	**Yes or No**

_____ _____

Patient Signature Date

_____ _____

Print Name Date of Birth

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Patient Acknowledgement Form

I have received the Notice of Privacy Practices, the HIPAA forms and the Patient Bill of Rights. I have been provided an opportunity to review it.

Print Name _____ Birth date_____

_____ _____

Signature Date

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Patient's Name _____ Date _____

Reason for your visit today _____

Past Medical History

(Do you have or have you ever had) ☐ **NONE**

- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast Cancer
- ☐ Cardiac Arrhythmia
- ☐ Cervical Cancer
- ☐ Cholesterol, elevated
- ☐ Colon Cancer
- ☐ Congestive Heart Disease
- ☐ COPD (Lung Disease
- ☐ Coronary Heart Disease
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ DVT (Venous Embolism)
- ☐ Epilepsy
- ☐ Esophageal Reflux
- ☐ Fibromyalgia
- ☐ Hepatitis (A, B or C)
- ☐ Hernia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Stone
- ☐ Lung Cancer
- ☐ Migraine Headache
- ☐ Mitral Valve Prolapse
- ☐ Myocardial Infarction
- ☐ Osteoporosis
- ☐ Ovarian Cancer
- ☐ Skin Cancer
- ☐ Stomach Cancer
- ☐ Stress Incontinence
- ☐ Stroke (CVA)
- ☐ Ulcer
- ☐ Uterine Cancer

Comments:

Past Gynecological History

(Do you have or have you ever had) ☐ **NONE**

- ☐ Abnormal PAP smear
- ☐ Amenorrhea (no menses)
- ☐ Anovulation
- ☐ Bartholin's Gland Cyst
- ☐ Cervical Cancer
- ☐ Chlamydia
- ☐ Condyloma Acuminatum
- ☐ Cystocele (Dropped Bladder)
- ☐ DES Exposure in Utero
- ☐ Dysplasia (Abnormal PAP)
- ☐ Dysfunctional Bleeding
- ☐ Dysmenorrhea
- ☐ Dyspareunia (painful sex)
- ☐ Ectopic Pregnancy
- ☐ Endometriosis
- ☐ Fibroid Uterus
- ☐ Gonorrhea
- ☐ Herpes Simplex (HSV)
- ☐ Hirsutism
- ☐ Human Papilloma Virus (HPV)
- ☐ Incontinence
- ☐ Infertility
- ☐ Irregular Menses
- ☐ Menorrhagia
- ☐ Ovarian Cyst
- ☐ Pelvic Inflammatory Disease
- ☐ PMS
- ☐ Polycystic Ovaries (PCOS)
- ☐ Recurrent Vaginitis
- ☐ Syphilis
- ☐ Trichomonas
- ☐ Uterine Polyps
- ☐ Uterine Prolapse

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Reproductive & Menstrual History

☐ **NONE**

Total # of Pregnancies	**Total # of Full Term Deliveries**	**Total # of Premature Deliveries**	**Total # of Multiple Births**
Total # of Terminations	**Total # of Miscarriages**	**Total # of Ectopic Pregnancies**	**Total # of Children Living**

Date of Delivery	**Gender of Baby**	**Weeks Gestation**	**C-Section or Vaginal**	**Weight of Baby**	**Anesthesia**	**Complications**

Date of Last Menstrual Period _____
At what age did your menstrual cycle begin? _____

Menopause Status _____
On Hormone Replacement YES NO

Yes	No		
☐	☐	Are your periods regular?	If irregular, how so? _____
☐	☐	Any recent changes with your periods?	If so, what are they? _____
☐	☐	Do you spot or bleed between your periods?	
☐	☐	Do you spot or bleed after intercourse?	

How many days between your periods? _____
How many days does your period last? _____
Are your periods light, medium or heavy? _____

Current method of birth control _____

Genetic History

☐ Chromosomal Disorder	☐ Genetic/Inherited Disorder	☐ Down's Syndrome
☐ Cystic Fibrosis	☐ Baby with Birth Defects	☐ Neural Tube Defects
☐ Sickle Cell Anemia	☐ Mental Retardation	☐ **NONE**

Comments:

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Past Surgical History

☐ Adenoidectomy
☐ Appendectomy
☐ Back Surgery
☐ Breast Augmentation
☐ Breast Lumpectomy
☐ Breast Mastectomy
☐ Bladder Lift
☐ Cesearan Section
☐ CABG (coronary bypass)
☐ Cholecystectomy/Gallbladder
☐ Colon Resection
☐ Colonoscopy
☐ Cystoscopy
☐ D & C
☐ Ectopic Pregnancy
☐ Endometrial Ablation
☐ Gastic Bypass
☐ Hemorrhoid
☐ Hernia
☐ Hip Replacement
☐ Hysteroscopy
☐ Hysterectomy (abdominal)
☐ Hysterectomy (vaginal)
☐ Hysterectomy (laproscopic)
☐ Knee Surgery
☐ Laparoscopy
☐ Ovary Removal
☐ Pacemaker Implant
☐ Shoulder Surgery
☐ Splenectomy
☐ Thyroidectomy
☐ Tonsillectomy
☐ **NONE**

Comments:

Medications

☐ **NONE**

Name of Medication Currently Taking	Dosage	Frequency	Reason for Taking

Allergies

☐ **NONE**

Allergen	Reaction

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General Health Screening

Date of last PAP Smear _____ Date of last Colonoscopy _____

Date of last Mammogram _____ Date of last Bone Density Scan _____

Yes	No		
☐	☐	Do you smoke?	If so, how much? ____ For how long ____
☐	☐	Have you ever smoked?	If so, how much? ____ For how long ____
☐	☐	Do you drink regularly?	If so, how many drinks per week? _____
☐	☐	Do you use other recreation drugs?	If so, which ones? _____
☐	☐	Do you exercise regularly?	
☐	☐	Do you perform a monthly breast exam?	
☐	☐	Are you sexually active?	If so, how many partners have you had? _____
☐	☐	Is sex satisfactory?	If not, what are your complaints? _____ _____
☐	☐	Have you ever had a colposcopy?	If so, when? _____
☐	☐	Have you had the Gardasil vaccine?	If so, did you complete the series? _____
☐	☐	Do you eat 3 meals per day?	
☐	☐	Do you eat snacks regularly?	
☐	☐	Do you have any eating problems?	
☐	☐	Any diet preferences/restrictions?	If so, what types? _____

Number of servings per day of vegetables & fruits _____
Number of servings per day of grains _____
Number of servings per week of red meat _____
Number of servings per day of dairy _____
Number of caffeinated beverages per day _____

Social History

What is your marital status? _____
What is your occupation? _____
Highest grade level achieved? _____

Yes	No	
☐	☐	Do you wear seatbelts?
☐	☐	Have you ever had a drug problem?

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Family History

Yes	No		Relationship	Age Diagnosed
☐	☐	Breast Cancer	_____	_____
☐	☐	Ovarian Cancer	_____	_____
☐	☐	Uterine Cancer	_____	_____
☐	☐	Male Breast Cancer	_____	_____
☐	☐	Cervical Cancer	_____	_____
☐	☐	Colon Cancer	_____	_____
☐	☐	Other Cancer	_____	_____
☐	☐	Osteoporosis	_____	_____
☐	☐	Hypertension	_____	_____
☐	☐	Heart Attack	_____	_____
☐	☐	Stroke	_____	_____
☐	☐	Diabetes	_____	_____
☐	☐	Mental Illness	_____	_____
☐	☐	Obesity	_____	_____
☐	☐	Alcoholism	_____	_____
☐	☐	Epilepsy or seizures	_____	_____
☐	☐	Gallstones	_____	_____
☐	☐	Glaucoma	_____	_____
☐	☐	Bleeding problems	_____	_____
☐	☐	Other	_____	_____

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Dear Patient,

The following are our financial office policies and procedures for ***Women's Care Group***.

REGISTRATION: In order for us to properly bill your insurance carrier all information requested is to be filled out properly & completely. Failure to fill in areas requested can delay or cause denials from your insurance company.

Co-Pays: Co-pays are always due at the time of service. Our office policy is not to bill you for your copays, since they are due at the time of service. If you ask our staff to bill you for your copay there will be a $10.00 service/processing fee. We accept cash, check, Visa and MasterCard.

Insurance Cards: **Current insurance cards are required at every visit**. If there are any changes to your insurance, including but not limited to, new insurance member identification number and/or group number, please inform the front desk at the time of check in and provide the updated card. If you are not the primary card holder, all information regarding the primary card holder is required to be filled out in full. Failure to fill in area can delay or cause denials or no payment from your insurance carrier. If this happens you may be asked to pay for all charges in full since we will not rebill your insurance carrier. **If you are new to our practice and are pregnant and present with commercial insurance, you are not allowed to switch to state insurance during the pregnancy. If you switch to state insurance during your pregnancy, you will be transferred out of our practice per our office policy.**

If you have not provided our office with the correct insurance information, you will be responsible for any balance due. We are unable to re-submit insurance claims.

Change in Personal Information: Please inform the front desk of any change in personal information by calling or writing the office at your earliest convenience. This includes, but is not limited to, change of address, telephone number, or last name. Failing to update personal information can delay communication regarding your health information.

Self-Pay Patients: If you do not have insurance, payment for your visit is due at the time of service. We accept cash, check, Visa and MasterCard. If you are a NEW PATIENT and are a self-pay, we will accept cash or credit card only.

Appointment Times: **Please try to make every effort to notify our office if you will be arriving late. New patients must arrive 15 minutes prior to scheduled appointment with New Patient Packet completed. If you show up any later than 15 minutes before scheduled appointment we will reschedule your appointment. If the New Patient Packet is not filled out completely we will reschedule your appointment.**

Missing an Appointment: We ask for 24 hour notice when canceling an appointment. A $50 missed appointment fee will be assessed to your account if 24 hour notice is not given when canceling or rescheduling an appointment; this includes but is not limited to missing your appointment for not having a current insurance card. Our office understands that emergencies do happen and for certain circumstances, the fee will be waived.

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Workman's Compensation: If your visit will not be submitted under your insurance plan, our office must have all necessary claim information before or at the time of your visit. If we are not provided with the correct information then you will be personally responsible for outstanding account balances.

Insurance & Employer Paperwork: (ex: FMLA) An appointment may be required to have forms completed. Our office charges $25 for all forms completed. This fee will be collected at the time forms are submitted.

Billing Statements: Our office sends out billing statements every 30 days to every patient with an outstanding balance. This balance usually reflects the remainder owed after your insurance has paid. It is your responsibility to pay your statement balance even if you and your insurance company are disputing coverage.

Collections: If your account balance is unpaid and overdue after three statements or more and we have been unable to contact you, your account will be referred to a collection agency. Any and all fees associated to your account being sent to a collection agency will be your responsibility. A 30% fee for all accounts sent to collections will be assessed. This fee will be the patients' responsibility to pay. Once your account is in collections, we will be unable to make any future appointments for you. Please note, we will only proceed to these measures if you do not respond to our attempts to communicate with you or set up a payment plan. Once your account is sent to collections, they will be contacting you.

Payment Plans: If you have negotiated a payment plan with us, you are responsible for making timely and consistent monthly payments. We offer payment plans as a courtesy to our patients in time of need. Please understand that we are not a bank or a financial institution and our payment plans are for a short time period, normally arranged to be paid off within 6 months. If you fail to make your scheduled weekly/bi-weekly or monthly payment and do not contact our office or respond to our attempts to contact you, your account may be sent to collections for non-payment.

After Hours Calls: Our office has a physician on call when the office is closed. This physician is to be called for emergencies only. A refill for a prescription is not usually considered an emergency and we ask that you have a refill request faxed to our office by your pharmacy. We will do our best to refill your prescription in a timely matter.

Medical Records: All requests by patients must be signed and in writing either by letter, fax, or a medical release of information form. Verbal requests will not be honored. A request is not necessary if the information is shared with a physician we have referred you to.

Copying Fees: Should you need your medical records copied, fees may apply.

Diagnosis Codes: Our office cannot recode an office visit because your insurance does not cover certain visits; this is illegal and considered fraud. It is your responsibility to know what your insurance plan covers. Always call your insurance company to verify coverage. It will be your responsibility to pay any unpaid amount that your insurance does not cover within 30 days.

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Test Results: Our office will notify you with the results from testing as soon as they become available to us and are reviewed by your physician. If you do not hear from us in a timely fashion, please call the office. However, our staff will not give results if they are waiting to be reviewed by the physician.

Test Orders, Referrals and Follow Up Care: Our office tracks test orders and referrals given to patients, as well as expected follow up care. An expected time frame for completion of these tests is assigned. If we have not received a report within the expected timeframe, you may receive a call or letter reminding you of the recommendation and the reason for the recommendation. We ask that you please respond with your intent to follow-up within a timely manner after receiving the reminder. Lack of response by the patient will be interpreted by the office that the patient assumes sole responsibility for the consequences of their inaction on this matter. Noncompliance could result in being discharged from the practice.

Uncooperative Patients: Physicians and staff members are not required to continue treatment of a patient who is uncooperative, refuses to follow treatment advice and presents difficulties in the doctor-patient relationship. Our goal is to try to accommodate all of our patients' needs to the best of our ability. Demanding and abusive language does not help us achieve that goal. Patients may be dismissed from our practice for this behavior.

Thank you for your Cooperation,

Women's Care Group

☐ By checking this box, I certify that I have read the above information and agree to follow the office policies and financial procedures of ***Women's Care Group***. I understand that if I do not follow these policies and procedures, I may be dismissed from the practice.

_____ _____

Print Name Date

_____ _____

Patient Signature Date