Advocate Medical Group

Chicago Urogynecology

3000 N. Halsted St., Suite 405 || Chicago, IL 60657 || T 773-296-7300 F 773-296-7390 || amgdoctors.com

Welcome to Chicago Urogynecology

Dear ______________________________,

Thank you for scheduling your appointment with ________________________, MD

______________________________ at ____________________________________.

It is our pleasure to welcome you to Chicago Urogynecology in advance of your first visit.

Enclosed in this welcome packet you will find your registration forms, a health history intake form and possibly a quality of life questionnaire depending on the reason for your visit. **These forms must be completed prior to your visit.** We ask that you please arrive **30 minutes** before your appointment time to better serve you.

When you arrive to our office, we will need your most current insurance card(s) and picture ID.

Note: All patients who have HMO insurance plan **MUST** have a referral from their primary care physician.

Any questions, or if you need to reschedule, do not hesitate to contact our office at (773)296-7300 and our staff will be more than happy to assist you. If you would like to send us previous medical records our fax number is 773-296-7390.

We appreciate your choice of medical care and we will do our best to serve your healthcare needs; once again, thank you and welcome to our practice.

Sincerely,

Donna Rice

Donna Rice
Practice Manager
(773)296-5942

Advocate Illinois Masonic Medical Center

Patient Registration Form

Date: ______________________ **Primary Care Provider** ______________________

Who referred you to us ______________________

1. Patient Information:

Last Name		First Name		Middle Initial
Street Address	Apt. #	City	State	Zip Code
Home Phone #/Cell Phone #	Social Security #		DOB - Month Date Year	
Patient's Occupation	Patient's Employer		Patient's Work #	
Patient's Employer Address			Patient's Working Hours	
Patient's Marital Status S M D W	Spouse's Name/Partner's Name		Other Names Used	

Best time of day to reach you: Time: Phone: ( )	May we leave test results or other info on your answering machine or voicemail? Yes/No Home/Work
Do you authorize anyone at your home to receive test results on your behalf? If so: Name:	Relationship:

2. Insured/Responsible Party Information: If the patient and the insured are the same, please skip #2 and complete number 3

Last Name		First Name		Middle Initial
Street Address	Apt. #	City	State	Zip Code
Home Phone #/Cell Phone #		Social Security #	DOB - Month Date Year	
Insured's Occupation	Insured's Employer		Insured's Work #	
Insured's Employer Address			Insured's Working Hours	

3. Emergency Contact Information/Relation______________ Ex: Spouse, Parent, Friend, etc.

Last Name		First Name		Middle Initial
Street Address	Apt. #	City	State	Zip Code
Home Phone #	Work Phone #		Working Hours	

______________________ ______________________

(Patient/Guarantor Signature **(Date)**

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Advocate
Illinois Masonic Medical Center

Ambulatory Care Services

Patients Rights

It is our belief that you, as a patient, have the right to:

- The best possible medical care, without regard to race, religion, sex, national origin, disability or method of payment for your care.
- Kind and respectful treatment by all personnel.
- Accept or refuse treatment.
- Ask questions of your doctor and other appropriate members of the health care team and to receive answers concerning your illness, condition, treatment and plans for your care.
- Discuss with members of the medical staff any treatment, procedure or operation planned for you so that you understand the purpose, probable results and/or alternatives, and risks involved before giving or refusing permission for this care.
- Know the names and responsibilities of the staff that provide your care.
- Be told about any research procedures or treatment that may be considered in your care, to discuss this research with the authorized individual, and to refuse the procedure should you so desire.
- Be examined and treated with care for your privacy and to have your privacy respected by all employees.
- Have all records and communications pertaining to your care kept confidential.
- Anticipate that our staff will make a reasonable response, within their capacity, to your request for service and you will be provided with information on how to obtain additional care/services if needed.
- Examine and receive an explanation of your bill for services upon request.
- Have you or your surrogate participate in the consideration of ethical issues that arise in the provision of your care. A request may be made to any staff person or physician by the patient or a family member to access support with ethical issues. Your advance directive or living will will be honored following assessment at a higher level of care.
- Have your complaints of pain evaluated.

Patient Responsibilities

We ask that you assume responsibility for:

- Providing complete information regarding health problems that you have had and any medication you may be taking.
- Carefully following the directions of the health care team, and accepting the consequences when these directions are not followed.
- Asking any questions that you have and expressing any complaints that may arise to your care provider or their supervisor. If these issues can not be resolved to your satisfaction, please contact Larry Wrobel, Vice President of Ambulatory Care at 773-296-7004.
- Acting with consideration and respect.
- Following the rules and regulations of the Health Care Center.
- Providing your primary physician with medical documentation from your visit, when requested.
- Reimbursing the organization for all services rendered. Please remember, regardless of the type of insurance you have, payment of your bill is your responsibility.

I certify that I have been informed of my rights and responsibilities as a patient.

_______________________ _______________________

Patient *Date*

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HEALTH CARE CONSENT

1. **TO TREAT.** I, for myself (or the patient named below) hereby consent to such diagnostic procedures and medical treatment as necessary and appropriate for my condition or illness in an Advocate emergency department, hospital or for a course of outpatient treatment in the judgment of my physician(s), to be performed by the hospital, nurses, other health care providers, and physicians. I understand that physicians, nurses and other health care providers in training may, under the supervision of appropriate personnel, participate in my treatment and I consent to such student involvement in my care.

2. **RESPONSIBILITY FOR PAYMENT.** In consideration of services to be rendered at the hospital, the undersigned agrees, as patient or guarantor for patient, to pay the hospital for all services, facilities and supplies provided to me or the patient at the established rates, including any deductible, co-payment or charges not covered by third party payors. I accept responsibility for any costs, including attorneys' fees, incurred in the collection of these charges. I understand that if I do not consent to release of records or later revoke such consent, I am fully responsible for payment of all charges for diagnosis and treatment received. I certify that the information given by me for purposes of payment for this hospital treatment is, to the best of my knowledge, complete and accurate. I understand that if I am having difficulty in meeting my payment responsibilities to the hospital, information on financial assistance including reasonable payment plans and charity care is available upon request as part of the hospital's financial counseling services.

3. **ASSIGNMENT OF BENEFITS.** In consideration of services rendered at the hospital, I hereby assign and authorize direct payment to the hospital and the treating physicians, any insurance, health plan or third party payor benefits otherwise payable to me or on my behalf for this hospitalization, emergency room or outpatient services.

4. **MEDICARE PAYMENT AND ASSIGNMENT OF BENEFITS** (if applicable). I request that payment of authorized Medicare benefits be made on my behalf for hospital and physician services furnished to me at the hospital and I assign such benefits to the hospital and physicians providing same. I certify that the information given by me in applying for such benefits is correct and that I have completed a Medicare questionnaire. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed for payments of such benefits. I authorize the Social Security Administration to release information about my entitlement to benefits to hospital and physicians providing services to me.

5. **RELEASE OF MEDICAL INFORMATION FOR PAYMENT.**
   - A. **General Release for Payment.** I hereby authorize the hospital and any physician or other healthcare provider who may treat me to release any and all pertinent information contained in my medical records, including HIV, to third party payors responsible for payment of patient charges including, but not limited to, insurance companies, health benefit plans, employers involved in approval of benefit claims, government agencies or intermediaries representing any of the above.
   - B. By initialing in the space below, **I do not consent** to the release of medical information concerning HIV diagnosis or treatment, if any, to third party payors and understand that I am personally responsible for payment for services.

     HIV ____

6. **DURATION AND REVOCATION OF AUTHORIZATION FOR RELEASE OF INFORMATION FOR BILLING.** This authorization to release information related to payment expires upon satisfactory payment of the bill. This authorization (or the refusal under paragraph 5 B), may be revoked at any time by written notice to the Health Information Management/Medical Records Department (with no effect on prior disclosures). If I revoke this authorization prior to satisfactory payment, I understand and accept that I am personally responsible for payment of all outstanding charges.

7. **PERSONAL BELONGINGS.** I assume full responsibility for all items of personal property, including but not limited to, eyeglasses, hearing aids, dentures, jewelry, currency and all other valuables. I understand that valuables may be kept in the hospital safe upon my request and hereby release the hospital of responsibility and liability for those valuables and items of personal property which are not deposited with the hospital for safekeeping.

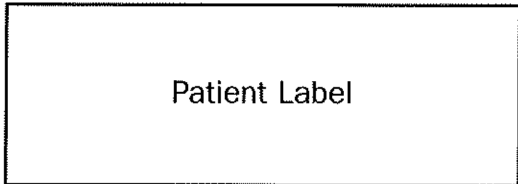
8. **INDEPENDENT PHYSICIAN SERVICES.** I acknowledge and fully understand that some or all of the physicians who provide medical services to me at the hospital are not employees or agents of the hospital, but rather independent practitioners on the hospital medical staff who are permitted to use the hospital facilities to render medical care and treatment. Non-employed physicians may include, but are not limited to, those practicing emergency medicine, trauma, cardiology, obstetrics, surgery, radiology, anesthesia, pathology and other specialties. My decision to seek medical care at the hospital is not based upon any understanding, representation, advertisement, media campaign, inference, implication or reliance that the physicians who are or will be treating me are employees or agents of the hospital. I understand that the hospital bill does not include physician services and I will receive separate physician bills. Some physicians on the medical staff may not participate in the same health plans as the hospital and I understand I may have to pay a higher proportion of the physician bill as an "out of network" provider.

I have read and understand the above terms of treatment and confirm that I am the patient or am authorized to sign on the patient's behalf.

Patient Name: ______________________________ **Date:** ____________________

Patient Signature: ______________________________ **Witness Signature:** ____________________
(or Parent/Legal Guardian, Personal Representative)

HEALTH CARE CONSENT FORM



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THE ATTACHED NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I have received the attached Advocate Health Care Notice of Privacy Practices.

X ______________________	X ______________________
Signature of Patient	Date of Signature Time
X ______________________	______________________
Patient's Printed Name	Date of Birth of the Patient or Medical Record Number
______________________	______________________
Signature of Parent/Legal Guardian/Legal Representative	Date of Signature Time
______________________	______________________
Parent/Legal Guardian/Legal Representative Printed Name	Relationship to Patient

This Notice is effective September 1, 2010.

5604004

Advocate Health Care

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Label

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Chicago Urogynecology

TO BETTER SERVE YOU, PLEASE PROVIDE THE FOLLOWING INFORMATION:

1. We must enter your preferred pharmacy into your electronic medical record. All prescriptions, **except** for controlled substances (Vicodin, Valium, etc.), are sent electronically to your pharmacy. **Please provide this information in the area below** .
2. **Please bring all your bottles of medications or a complete detailed list of your medications with the dosage, instructions, and prescribing doctor**.
3. Also, it is important for us to know the list of your allergies to medications and your body's reaction to the medication (hives, shortness of breath, swelling, and etc.) **Please provide this information below.**

Patient Name: ______________________ **DOB:** ______________

PHARMACY INFORMATION:

NAME: ______________________

ADDRESS: ______________________

____

PHONE: ______________________

ALLERGY INFORMATION: Please check one of the following and provide the information

( ) I do not have any allergies to medication

( ) I do have allergies to medication and/or food (Please list below)

____

____

____

____

Inspiring medicine. Changing lives.

Date: ______________________

Name: ______________________

DOB: ______________________

My Advocate Portal

In order to better serve you, we are proud to introduce **My Advocate Patient Portal.**

My Advocate patient portal is a free, password protected and web-based interactive service that allows you to securely access, track, and even update your health information.

You will be able to view your medical information and recent test results.

If you would like to sign up, please provide an email and we will send you a confirmation link.

( ) Sign me up!

Email:

____

( ) No thanks!

Advocate Medical Group

Intake History

Name: ________________________________ Birthdate: ___ /___ /___ Date: ___ /___ /___

Why are you here today? ________________________________

____

____

PAST OR CURRENT MAJOR ILLNESS					
	YES	NO		YES	NO
Asthma			Anemia/Blood transfusion		
Pneumonia			Seizures/convulsions/epilepsy		
Chronic Lung Disease			Bowel trouble		
Kidney Infections/Stones			Glaucoma		
Tuberculosis			Arthritis/joint pain		
Venereal Disease			Fracture		
Heart Trouble/Murmur			Hepatitis/Yellow jaundice		
Diabetes			Thyroid Disease		
High Blood Pressure			Peptic Ulcer Disease		
Stroke			Irritable Bowel Syndrome		
Rheumatic Fever			Inflammatory Bowel Disease		
Cancer			Hemorrhoids		
Ulcers			Gallbladder Disease		
Depression/anxiety			HIV		

OPERATIONS/HOSPITALIZATIONS			
Reason	Date	Reason	Date

LAST IMMUNIZATION OR TEST			
	Date		Date
Tetanus		Hep A	
Flu Shot		Hep B	
Pneumonia		MMR	
TB Skin Test		HIB	

OBSTETRICAL HISTORY						
Date Pregnancy Ended	# of months Pregnant	Delivery Type	Abortion	Miscarriage	How did your pregnancy end? Complications?	Doctor/Hospital

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GYNECOLOGICAL HISTORY
Method of birth control used?
First day of last menstrual period?
Do you have a period each month?
How many days do you usually bleed?
Do you bleed between periods?
Do you have pain, bleeding or other problems during intercourse?
History of sexually transmitted diseases?
History of abnormal papsmears? When?
History of breast problems/Surgery?
Do you examine your breast regularly?
Have you ever had a mammogram? When?
Do you lose urine when you cough or sneeze?

CURRENT MEDICATIONS	
Drug Name - How much? How Often?	Drug Name - How Much? How Often?

FAMILY HISTORY					
ILLNESS	**YES**	**RELATIVE**	**ILLNESS**	**YES**	**RELATIVE**
High Cholesterol			Osteoporosis		
Fibroids			Mental Illness		
Diabetes			Drinking Problem		
Stroke			Breast Cancer		
Heart Disease			Colon Cancer		
High Blood Pressure			Ovarian Cancer		
			Other Cancer		

SOCIAL HISTORY				
	YES	**NO**		
Smoking			Packs per day	Years
Alcohol			Drinks per day	Drinks per week
Drug Use				
Seat Belt Use				
Regular Exercise				
Have you ever been physically hurt or abused by anyone?				
Marital Status Married ☐ Single ☐ Widowed ☐ Divorced ☐				

REVIEW OF SYSTEMS

PLEASE (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST OR OFTEN			
1. CONSTITUTIONAL	Currently	Past	Notes
Weight loss	☐	☐	
Weight gain	☐	☐	
Fever	☐	☐	
Fatigue	☐	☐	
2. EYES	Currently	Past	
Double vision	☐	☐	
Spots before eyes	☐	☐	
Vision changes	☐	☐	
3. ENT/Mouth	Currently	Past	
Hearing loss	☐	☐	
Ear aches	☐	☐	
Ringing in ears	☐	☐	
Sinus problems	☐	☐	
Sore throat	☐	☐	
Mouth sores	☐	☐	
Dental problems	☐	☐	
4. CARDIOVASCULAR	Currently	Past	
Painful breathing	☐	☐	
Chest pain or pressure	☐	☐	
Difficult breathing on exertion	☐	☐	
Swelling of legs	☐	☐	
Palpitations of heart	☐	☐	
Murmur	☐	☐	
5. RESPIRATORY	Currently	Past	
Wheezing	☐	☐	
Spitting of blood	☐	☐	
Shortness of breath	☐	☐	
Cough, chronic	☐	☐	
6. GASTROINTESTINAL	Currently	Past	
Diarrhea, frequent	☐	☐	
Bloody stool	☐	☐	
Nausea/vomiting	☐	☐	
Constipation	☐	☐	
7. GENITOURINARY	Currently	Past	
Blood in urine	☐	☐	
Pain with urination	☐	☐	
Urgency	☐	☐	
Frequency of urination	☐	☐	
Incomplete emptying	☐	☐	
8. MUSCULOSKELETAL	Currently	Past	
Muscle weakness	☐	☐	

9. SKIN/BREAST	Currently	Past	
Pain in breast	☐	☐	
Discharge	☐	☐	
Masses	☐	☐	
Rash	☐	☐	
Ulcers	☐	☐	
10. NEUROLOGICAL	Currently	Past	
Dizziness	☐	☐	
Seizures	☐	☐	
Numbness	☐	☐	
Trouble walking	☐	☐	
11. PSYCHIATRIC	Currently	Past	
Memory disturbance	☐	☐	
Depression	☐	☐	
Crying, frequent	☐	☐	
12. ENDOCRINE	Currently	Past	
Dry Skin	☐	☐	
Abnormal Thirst	☐	☐	
Hot Flashes	☐	☐	
13. HEMATOLOGIC/LYMPHATIC	Currently	Past	
Blood clots	☐	☐	
Bruises, frequent	☐	☐	
Cuts do not stop bleeding	☐	☐	
Enlarged lymph nodes	☐	☐	
14. ALLERGIC/IMMUNOLOGIC	Currently	Past	
Allergies	☐	☐	
Drugs, other	☐	☐	

Signature of Patient: ______________________________

Date reviewed by physician with patient: ______________________________

Physician Signature: ______________________________

HISTORY REVIEWED:

Date: ____________ Physician Signature: ______________________________

Date: ____________ Physician Signature: ______________________________

Date: ____________ Physician Signature: ______________________________