Your Name: _____ Today's Date: _____
(First) (Middle) (Last)

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Maiden Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ Cell: (____) _____ Birthdate: _____ Age: _____

Email Address: _____

Occupation: _____ Social Security #: _____

Employer: _____ Length of Employment: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employer's Telephone: (____) _____ Ext. _____

Name of Spouse or Responsible Party _____ Birthdate: _____ Age: _____

Occupation: _____ Social Security #: _____

Employer's Telephone: (____) _____ Ext. _____

Name and Address of Insurance Company: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____

Group Number: _____ Policy ID#: _____

Effective Date of Coverage: _____

Name of Pharmacy: _____ Telephone: (____) _____

I authorize the release of any medical information necessary to process this claim. I also authorize payment of medical and surgical benefits to Chams Women's Healthcare. Please remember you are responsible for all fees, regardless of insurance coverage. Please also note that there will be a cancellation fee applied to any missed appointment in which the patient did not give at least a 24 hour notice.

Signed: _____ Date: _____
(patient or authorized person)

In case of emergency, contact: _____ Relationship: _____

Home Telephone: (____) _____ Cell Phone: (____) _____

How did you learn about our practice? _____

Referred by Dr. _____ Address: _____ Zip: _____
Full Name

Patient Financial Policy

Initials_____ & Date_____

Thank you for choosing Chams Women's Health Care, SC for your health care needs. This patient financial policy has been developed to assist in answering your questions regarding patient and insurance responsibility for services rendered. Your understanding of and compliance with our patient financial policy is important. Please read the policy below and ask the staff any questions you may have and sign as indicated. The original will be maintained in your file and a copy may be provided to you upon your request.

1. PROOF OF INSURANCE:
All patients must complete our patient information form before seeing the physician. Chams Women's Health Care, SC participates with a large variety of insurance plans. Please confirm with your health plan that we participate with your specific insurance plan. If you are **NOT** covered by an insurance plan, payment in full is expected at the time of service. It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card.

2. UPDATED CHANGE OF INFORMATION & COVERAGE:
We will ask you to update this whenever you have a change in address, employment, insurance, etc. However, it is your responsibility to make us aware of these changes and if you fail to provide us with the correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.

3. CO-PAYMENTS, DEDUCTIBLES & CO-INSURANCE:
All co-payments, deductibles & co-insurance must be paid at the time of service. Payment of your co-payments, deductibles & co-insurance is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered as an act of fraud by your insurance plan.

4. REFERRALS OR NON COVERED SERVICES:
Some insurance plans require a referral from a primary care physician to obtain services of a specialist, such as a cardiologist. These health plans will not pay for services rendered without a referral. It is 'YOUR' responsibility to obtain a referral prior to treatment. If you have not obtained the necessary referral, you may either reschedule your appointment or, if allowed by your insurance company, sign a waiver agreeing to pay for the service at the time it is rendered. Please be aware that some or perhaps all of the services you receive my not be covered or considered reasonable or necessary by your insurance plan. If you elect to have these services, you will be asked for payment in full at the time of service.

5. AUTHORIZATIONS: Obtaining a prior authorization for services and medications is not a guarantee of payment of benefits. A prior authorization means that the information given at that time meets the medical necessity for the services not a guarantee of payment. Your insurance plan will confirm to you that even though the services may be authorized, the services may not be covered under your plan and a decision for payment will not be rendered until a claim is submitted. Any prior authorizations that need to be performed by our office staff will incur $25.00 administrative fee.

6. CLAIMS SUBMISSION: We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely comply to your insurance plan's request may result in your claim denial and if so, will result in our seeking full reimbursement from you for services rendered; even if we are a participating provider with your plan. Your insurance benefit is a contract between you and your insurance plan.

7. NON-PAYMENT: If your account is past due, and we have not received a response from you, your account may be turned over to a collection agency. Reasonable collection fees will be your responsibility to pay in addition to the principal balance.

8. **FINANCE CHARGES**: Finance charges will be applied to past due balances after 60 days. The account balance will be subject to a $10.00 charge per month unless other arrangements are made in advance with this office.

9. **PAYMENT METHODS:** We accept cash, personal checks, money orders, cashier's check, MasterCard, and Visa as payment for services rendered. Credit card transactions are subject to a 4% service fee.

10. **RETURNED CHECKS:** A returned check fee of $50 will be added to your account for every check returned for insufficient funds, stopped payment or closed accounts. After the second occurrence, only cash, money orders, cashier's check or credit card payments will be accepted.

11. **NO SHOW POLICY**

APPOINTMENTS:

Missed, cancelled, or rescheduled appointments in less than 24 hours will incur a $100 fee.

SURGERY OR PROCEDURES:

1. Missed**,** cancelled, or rescheduled surgeries less than 7 days notice will incur a $500 fee.
2. Missed, cancelled, or rescheduled surgeries more than 14 days out will incur a $250 administrative fee.

12. **DISABILITY FORMS:** Any paperwork that needs to be filled out is subject to a $25.00 charge.

*****Knowing your insurance benefits is your responsibility. Please contact your insurance plan with questions you may have regarding your coverage*****

This is an agreement between Chams Women's Healthcare and the patient/responsible party signed below. By executing this agreement, you are agreeing to pay for all services that are received.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINE.

Patient's Name:_____

Signature of Patient or Responsible Party_____

Date_____

PATIENT / RESPONSIBLE PARTY SIGNATURE

****** PLEASE READ THIS IMPORTANT INFORMATION ******

To our Patients:

We would like to inform you of our guidelines regarding our billing practices and keep you informed of the correspondence you will receive from our practice. We have outlined the processes we follow to insure we are working diligently with your insurance to collect payment for our services. Keep in mind that we do not know what your benefit levels are and encourage our patients to play a proactive part in understanding the mechanisms of their insurance. All balances that are transferred from insurance to patient responsibility are done as a result of insurance non-payment.

Days After Your Service	Statement/Purpose	Patient Action
0-30 days	**1st statement** = Informing patient that insurance has been billed. No patient payment due at this time.	None
31-60 days	**2nd statement**= Insurance will be followed up with inquiring status of claim. Any supplemental information required by the office will be submitted, if needed by insurance carrier. No patient payment due at this time.	None
61-90 days	**3rd statement** = Insurance has either: [1] paid on claim and balance is patient responsibility; or [2] denied payment and balance is patient responsibility; or [3] requires information from patient to process claim.	[1] Patient is to pay balance in full. [2] Pay balance in full and follow up with insurance to obtain reimbursement. [3] patient must call insurance and submit required information within 14 days or balance will be patients responsibility.
91-120 days	**4th statement** = At this point it is no longer an insurance issue. Balance is the patient's responsibility. ***This forth statement is a pre-collection notice.***	Patient must pay balance. This is the pre-collection stage. If not paid in full by the end of that month, patient will be forwarded to collection agency.

Please note that payment arrangements can be made but we hold a strict consistency in patients making their payments. Once the payment schedule is broken, the balance will be due in full.

Payment arrangements will be offered in the following manner:

BALANCE AMOUNT	PAYMENT AMOUNT	MAXIMUM TERM
20.00 to 100.00	Payment in Full	0 months
100.00 to 300.00	25% down	3 months
300.00 to 500.00	25% down	6 months
500.00 and over	25% down	9 months

Chams Women's Healthcare, S.C.

NOTICE OF PRIVACY PRACTICES

THIS 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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health care operations.

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would be a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute unidentified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or that you are due to receive periodic care from the practice or other health-related benefits and services that may be of interest to you. This contact may be done by phone, in writing, or by mail and may involve leaving a message on an answering machine.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Office Manager.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. The right to inspect and copy your protected health information and we may charge a fee for the costs of copying and mailing.
- The right to request an amendment be made to your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Security of the Department of Health and Human Services. To file a complaint with Chams Women's Healthcare, S.C., contact our office manager, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.

CHAMS WOMEN'S HEALTH CARE, S.C.

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices

I, _____, hereby give my consent to Chams Women's Health Care
(Name of Patient or Authorized Agent)
to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _____.
(Patient's Name)

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a 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 if I make this request, in writing, to the Privacy Officer. The revised Notice will be posted in our office in a prominent location.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the practice. I also understand that I will not be able to revoke this consent in cases where the practice has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the practices office and Privacy Officer.

I permit the following individual or individuals to have access to my file and any results.

____No one except myself

____Name_____Relationship_____

____Name_____Relationship_____

Signed: _____Date: _____

If you are not the patient, please specify your relationship to the patient _____.

- ❑ Patient received copy of "notice of privacy practices"

– Patient's file

Chams Women's Health Care, S.C.

JOYCE CHAMS, M.D., FACOG

PATIENT PRE-SCREENING COVID-19 QUESTIONNAIRE

We appreciate your cooperation and patience in helping to keep our patients and staff safe and healthy.

1. **Have you traveled outside the U.S. in the past 30 days?**

   Yes No

2. **Have you traveled to a U.S. state with high reported cases of Coronavirus in the past 30 days?**

   Yes No

3. **Have you been in personal contact with a person infected with Coronavirus or who has traveled to an area with widespread and ongoing transmission of Coronavirus in the past 30 days?**

   Yes No

4. **Have you ever received a dose of Covid-19 vaccine?**

   Yes No

   If yes, which vaccine product did you receive?

   Pfizer Moderna Other _____

   Dates #1 _____ #2 _____

5. **In the last 14 days:**

Have you had a fever above 99.5?	Yes	No
Or Have you experienced any :		
Coughing	Yes	No
Sore Throat	Yes	No
Difficulty Breathing	Yes	No
Muscle Aches	Yes	No
Stomach Pain	Yes	No
Loss of Taste/Smell	Yes	No

Signature_____ **Date**_____

2601 Compass Road, Suite 115 • Glenview, Illinois 60026
(847) 998-4637 • Fax (847) 998-4649

Chams Women's Health Care, S.C.

JOYCE CHAMS, M.D., F.A.C.O.G.

CANCER RISK ASSESSMENT INTAKE FORM

PATIENT NAME _____

DATE OF BIRTH _____

Please check all boxes that apply:

	PERSONAL	RELATIVE (include relationship)
1. Breast Cancer at age ≤50	☐	☐ _____
2. "Triple Negative" Breast Cancer (Estrogen Receptor (ER) negative, Progesterone Receptor (PR) negative, HER2neu negative)	☐	☐ _____
3. Ovarian, fallopian tube, or primary peritoneal cancer	☐	☐ _____
4. Male breast cancer	☐	☐ _____
5. Bilateral breast cancer (cancer in both breasts) or two breast primaries (1 dx'd <50 yrs)	☐	☐ _____
6. Ashkenazi (Eastern/Central European) Jewish ancestry with breast or ovarian cancer	☐	☐ _____
7. Pancreatic or Prostate Cancer (High grade/ Gleason score ≥7) with a family history of breast or ovarian cancer	☐	☐ _____
8. Colorectal cancer or several pre-cancerous polyps (adenomas) at an age ≤50	☐	☐ _____
9. Endometrial (uterine) cancer at age ≤50	☐	☐ _____
10. 10 or more total pre-cancerous polyps (adenomas) in a person's lifetime	☐	☐ _____
11. Two or more cases of the same type of cancer on one side of the family (ex. breast, ovarian, kidney, sarcoma, thyroid, melanoma)	☐	☐ _____
12. History of multiple primary cancers	☐	☐ _____
13. Personal and/or family history of a known genetic mutation	☐	☐ _____

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