NewBeginnings
Obstetrics and Gynecology
2127 Midlands Ct. Sycamore, IL 60178 Phone: (815) 517-1677 fax: (815) 517-1669

PATIENT INFORMATION	**DATE / /**
Patient Name	Social Security # / /
Mailing Address	Date of Birth / /
Zip State	Marital Status
CONTACT INFORMATION	
Home Phone Cell Phone	Work Phone
Email Address	
EMERGENCY CONTACT	
Emergency Contact	
Relationship to Patient	Phone Number
Primary Care Physician	Phone Number
PHARMACY NAME AND LOCATION	

FINANCIAL POLICY AND CHARGES

We will continue to bill your primary insurance company as we always have. When your insurance company pays their portion of your claim, we will send you a patient statement, detailing your balance, **as determined by your insurance company.**
You will have 14 days from the postmarked date of your statement to do one of the following:

1. Make payment in full to the office
2. Pay off the balance in three equal installments (no more than 90 days)
3. We also accept CareCredit
4. Patient must pay ultrasound outstanding balance before next the ultrasound

Init._____ ➢ FMLA PAPER/ Medical paperwork $45.00……. $25 will be charged for any subsequent revision
Init_____ ➢ MEDICAL RECORDS $45.00
Init_____ ➢ If you had not cancelled your appointment at least 24 hours in advance, New Beginnings OB/GYN, will charge you **No Show fee 45.00**

A no-show fee is a separate charge that will not be covered by your insurance plan. Also, after three no-show appointments, you will be discharged from the practice.

I hereby certify that the information provided to New Beginnings Ob/Gyn to be true and correct

Name: _____ Date: _____

I authorize payment of insurance benefits to the physician/practice submitting claims on my behalf.
Name: _____ Date: _____

Signed: _____ Date: _____

HOW DID YOU HEAR ABOUT US?

☐ Internet Search ☐ Family/Friend ☐ Former Patient ☐ YouTube ☐ Insurance ☐ Physician Referral ☐ Website ☐ Other

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1. **General Consent to Medical Treatment**
   I hereby request and consent New Beginnings Obstetrics and Gynecology and their employees and agents ("Dr.Rana") to attend me during my treatment and perform routine tests and procedures and to provide certain healthcare services as prescribed for my health and well-being. I acknowledge that no representatives, warranties, or guarantees as to results of cures that have been made to me by Dr. Rana, nor have I relied upon any such representations, warranties, or guarantees. I understand that physicians who hold limited licenses to practice medicine and are in residency programs and/or other health career students may assist with me care and treatment, within the scope and limitation of the applicable health education program, during my office visit.

2. **Consent to Photograph**
   I hereby consent to present a photo identification to confirm my identity as a patient who will receive treatment from Dr. Rana.

   Photographs may be taken with a New Beginnings Obstetrics and Gynecology owned camera for a assessment and treatment of medical conditions. I understand that the photographic image will be stored in my confidential medical record.

   Initial here if you are declining to have your photograph taken for treatment purposes: _____

3. **Financial Agreement**
   I hereby agree to pay Dr. Rana their charges for all services rendered during my treatment. I shall also be responsible for any cost of collection and attorney fees required to collect for these services, to which may be added interest at the current legal rate. I hereby assign directly to Dr. Rana payment to any health insurance benefits, including but not limited to any and all applicable Medicare and Medigap benefits, applicable to this treatment and authorize the release of information necessary to determine coverage and to permit reimbursement on my behalf to Dr. Rana. Such payments, however, shall not exceed my balance owed to Dr. Rana. I hereby certify that any information, which I have given in applying for coverage under Title XVII and/or Title XIX of the Social Security Act, or ant insurance or other information, which I provided, is true and correct.

4. **Revocation of Consent**
   I may revoke this consent at any time except to the extent that any New Beginnings Obstetrics and Gynecology has already taken action in reliance on it.

   For any line item of this consent I have initiated in the designated area indicating a declination, I understand that indicates I do not agree with that section and do not consent to the options describes in that section.

   I agree that I have read this form carefully and agree that everything in this agreement applies to current and futurehealth care services provided by New Beginnings Obstetrics and Gynecology.

_____

Patient Signature Date

_____

Patient's Legal Guardian or Responsible Party Signature (if applicable) Date

_____

Witness Date

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NOTICE OF PRIVACY PRACTICES
Acknowledgement Form

By signing below, I acknowledge that I have been offered or received a copy of the Notice of Privacy Practice ("Notices"). I understand that I may obtain a written copy of this Notice at the time upon request or via the website at newbeginnings-obgyn.com

Name of Patient | Date of Birth

Patient or Legal Guardian Signature | Date

Witness Signature | Date

Reason Given by Patient if Refusing to Sign this Notice

☐ I authorize the Practice to discuss my Health Information with,

(Name):

Address | Phone Number:

Patient or Legal Guardian Signature | Date

Scan to: HIPAA Notice of Privacy Practice

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AUTHORIZATION TO OBTAIN PATIENT MEDICAL RECORDS

I AUTHORIZE_____

TO RELEASE THE BELOW INFORMATION FROM MY HEALTH RECORD(S)

Address: _____**Ph:**_____**Fax:**_____

Patient Name (Please Print):_____

Patient Address: _____

Date of Birth: _____ Last 4 digits of Social Security # _____Patient telephone#: _____

Covering the period(s) of treatment: _____

PURPOSE OF DISCLOSURE: _____ Continuation of Care _____ Insurance _____ Attorney _____Personal Use _____Other

INFORMATION TO BE RELEASED:

☐Radiology ☐Lab Results ☐Procedure Note ☐Consultations ☐Gynecologic Records ☐Complete Record

☐Other (specify):_____

INFORMATION TO BE RELEASED TO:

Name: New Beginnings Obstetrics and Gynecology

Address: 2127 Midlands Court. Suite 204, Sycamore, IL 60178-3119

Telephone: 815.517.1677 Fax: 815.517.1669

I understand this authorization can be revoked by me at any time in writing to (Physician office Name) except that disclosure made in good faith has already occurred in reliance on this authorization. (Physician Office Name) will not condition treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed except as allowed under the HIPPA regulation.

I understand that a fee may be charged for preparing a copy of the requested records. I understand that information used or disclosed pursuant to this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days.

Your protected health information will be provided to you in paper format. If you wish for your protected health information to be provided to you on electronic media that meets the HIPPA and HITECH requirement, you must initial here_____.

I understand that this release also pertains to records regarding the testing and **treatment for alcohol/substance abuse, human immunodeficiency virus (HIV) and /or AIDS, or for psychiatric treatment or counseling or communicable disease, unless I have initialed here**:_____

SIGNATURE: _____DATE:_____

RELATIONSHIP TO PATIENT, if other than patient: _____

DESCRIPTION OF AUTHORITY TO ACT FOR PATIENT (if applicable) _____

WITNESS SIGNATURE: _____ DATE: _____

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CANCELLATION & NO-SHOW POLICY

At New Beginnings OB/GYN our goal is to provide quality individualized medical care in timely manner. No-shows, late show, and cancellations is an inconvenience to other patients who need access to medical care.

If you arrive 15 minutes or more after your appointment time, that shall consider you a no-show.

This includes appointments for ultrasound, nurse visit, and lab work.

If you do not show up for your appointment AND if you had not canceled your appointment at least 24 hours in advance, New Beginnings OB/GYN, will charge you a "no-show fee". The amount of the no-show fee will be $45.00 and missed procedures will result in a no-show fee of $55.00.

A no-show fee is a separate charge that will not be covered by your insurance plan. Also, after three no-show appointments, you will be discharged from the practice.

You will need to pay the no-show fee in full before you schedule any future appointments.

Medicaid patients who are not attending their appointment will also be notify to the County Health Department

We understand the New Beginnings OB/GYN no-show policy and agree to pay the new Beginnings OB/GYN no-show fees above if I am a no-show and had not call the office at least 24 hours in advance of my appointment to cancel.

Patient's name (Print) Patients signature Date

_____ _____ _____

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INDEPENDENT CONTRACTOR FOR ULTRASOUND SERVICES

At New Beginnings Obstetrics & Gynecology, we want to provide the highest quality services for our patients. In doing so, Mother & Child Ultrasound, LLC, DBA Medpro Mobile (and agent), who is a registered ultrasound technician, performs many of our ultrasound procedures in the office. She has many years of experience in performing ultrasounds and has worked in hospitals and other doctors' offices in many different communities, Mother & Child Ultrasound, LLC, DBA Medpro Mobile is an independent contractor and not an employee of New Beginnings Obstetrics & Gynecology. You will not receive a separate billing statement regarding these services. Please take the time to read the above and we can answer any questions you may have.

I have read the above statements and I understood that Mother & Child Ultrasound, LLC, DBA Medpro Mobile (and agent) is not an employee or sub company of New Beginnings Obstetrics and Gynecology and is an independent contractor.

Printed Name: _____

Patient Signature. _____ Date. _____

Witness. _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

NAME: _____ **DATE OF BIRTH:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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**
☐	☐	☐	☐

Signature: _____ **Date:** _____

RISK ASSESSMENT FOR HEREDITARY CANCER SYNDROMES

Patient Name: _____ Provider: _____

Date of Birth: _____ Today's Date: _____

Reason for Today's Visit: _____ Insurance Company: _____

This is a screening tool for cancers that run in families. Please consider the following blood relatives:
Mother/Father/Sister/Brother/Children Aunt/Uncle/Niece/Nephew Grandparent

Have you or any of your relatives been tested for a hereditary cancer syndrome? YES _____ NO _____

Have YOU been diagnosed with cancer? What site (organ)? _____ What age? _____

FAMILY HISTORY OF CANCER			SELF	WHICH FAMILY MEMBER (consider parents, children, siblings, aunts/uncles, nieces/nephews, and grandparents)	
				MOTHER'S SIDE	FATHER'S SIDE
(Y)	*N*	*EXAMPLE: Breast cancer **BEFORE AGE 50***	-----	----------	*Aunt, age 48*
Y	N	Ovarian cancer **AT ANY AGE**			
Y	N	Breast cancer **BEFORE AGE 50**			
Y	N	3 or more breast cancers on the same side of the family **AT ANY AGE**			
Y	N	**YOU** had a diagnosis of breast cancer **AT ANY AGE**			
Y	N	Male breast cancer **AT ANY AGE**			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer **AT ANY AGE**			
Y	N	**YOU** had colorectal or uterine (endometrial) cancer **BEFORE AGE 65**			
Y	N	1 colorectal or uterine (endometrial) cancer, **BEFORE AGE 50**			
Y	N	3 or more colorectal or uterine (endometrial) cancers **AT ANY AGE**			
Y	N	You or a family member have **20 or more colon polyps** (in a lifetime)			
Y	N	Pancreatic cancer **AT ANY AGE**			

FOR OFFICE USE ONLY

☐ Patient meets criteria for genetic testing: ☐ YES ☐ NO

☐ Patient was offered genetic testing today: ☐ YES ☐ NO

☐ Patient **DECLINED** recommended genetic test:

Healthcare Provider Signature: _____

Patient signature if declining recommended testing: _____