**HAROLD A. NORD OBSTETRICS & GYNECOLOGY S.C.**
Rachel M.H. Dalton, D.O.
1302 Franklin Avenue, Suite 2800, Normal, IL 61761
Phone: 309-454-3456 Fax 309-454-6977

Thank you for scheduling an appointment with our office. It is our pleasure to welcome you to Harold A. Nord, Obstetrics & Gynecology, S.C. in advance of your first visit.

In this packet you will find some patient information that will help familiarize you with the practice and how we operate. If you have any questions after reading the material, please feel free to phone us and we will be address them prior to your visit. We have also included our Patient Information Form and Acknowledgment of Receipt of Notice of Privacy Practices Form. After reviewing, please complete these forms and bring them with you to your appointment. In addition, please bring your insurance card and a photo I.D., so that we may have a copy for our records. We would like to remind you, that understanding your insurance coverage is the patient's responsibility. We recommend that you call your insurance to be aware of how they cover office visits and what hospital they will cover. Being informed of these preferences ensures you will have the optimum payment of services and no surprises when billed.

We invite you to acquaint yourself with our office philosophy and be introduced to the staff by viewing all areas of our website, before your scheduled appointment time.

We appreciate you selecting our office for your medical care. Our entire staff will work hard to serve your needs.

Serving Christ through healthcare,

Dr. Rachel Dalton

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# FINANCIAL POLICY

It is our hope that you will understand that our office financial and billing policies are necessary to maintain vital health care services to our patients and community.

Our practice is committed to providing the best treatment possible for our patients and we charge what is *usual and customary* in this area. You are responsible for payment in full, regardless of any insurance company's arbitrary determination of usual and customary rates.

## INSURANCE AND BENEFITS

*Remember that insurance is a contract between you and your insurance company and it is your responsibility to understand the basic coverage of that contract. Please check with your insurance company to verify if a referral is required prior to your visit and what their preferred hospital choice is.*

## PAYMENTS

- Co-payments will be collected on the day of your appointment, as you check in. All insurance companies require that the physician collect all co-pays from the patient.
- *According to the American Medical Association CPT coding & guidelines, our office charges for treatment & diagnosing over the phone from our doctor, nurse practitioners & nurses.*

## OFFICE PAYMENTS

We request that all office visit charges and office procedures be paid at the time of service, unless you are covered by an insurance plan that we are currently enrolled in.

**WE ACCEPT CASH, CHECKS, DISCOVER CARD, VISA & MASTER CARD CREDIT CARDS.**

## PAYMENT PLANS

In circumstances where a claim is pending, or no insurance coverage exists, a payment plan may be initiated through our billing department. We will be pleased to cooperate with you in establishing a payment plan, prior to services provided.

## CANCELLATIONS/NO SHOW

Our office is looking forward to participating in your healthcare. We ask that if you are unable to keep your scheduled appointment, please make every effort to contact our office at least 24 hours prior to the appointment date. In the event that you miss 3 or more appointments without cancelling, the provider may decide to discontinue your care with this office.

Patient Name _____ Date of Birth _____

Patient Signature _____ Date _____

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## PATIENT INFORMATION

| NAME | SSN# | BIRTHDATE | LANGUAGE | SEX (circle) M F |
|---|---|---|---|---|
| | | | | |

| ADDRESS | CITY, STATE, ZIP |
|---|---|
| | |

| HOME PHONE | CELL PHONE | WORK PHONE | PRIMARY CARE PROVIDER |
|---|---|---|---|
| | | | |

| MARITAL STATUS | STUDENT STATUS Full Time ____ Part Time ___ | EMERGENCY CONTACT NAME | EMERGENCY CONTACT PHONE |
|---|---|---|---|
| | | | |

| PRIMARY EMPLOYER | EMPLOYER ADDRESS | EMPLOYER CITY, STATE, ZIP |
|---|---|---|
| | | |

## RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

| NAME | SSN# | BIRTHDATE | LANGUAGE | SEX (circle) M F |
|---|---|---|---|---|
| | | | | |

| ADDRESS | CITY, STATE, ZIP |
|---|---|
| | |

| HOME PHONE | CELL PHONE | RELATIONSHIP TO PATIENT |
|---|---|---|
| | | |

## PRIMARY INSURANCE

| NAME OF INSURANCE COMPANY | POLICY # | |
|---|---|---|
| | | |
| NAME OF INSURED | GROUP # | |
| | | |
| ADDRESS OF INSURANCE COMPANY | CITY, STATE, ZIP | |
| | | |
| INSURANCE COMPANY PHONE # | COPAY AMOUNT | |
| | | |
| RELATIONSHIP TO PATIENT | EFFECTIVE DATE | EXPIRATION DATE |
| | | |

## SECONDARY INSURANCE (IF APPLICABLE)

| NAME OF INSURANCE COMPANY | POLICY # | |
|---|---|---|
| | | |
| NAME OF INSURED | GROUP # | |
| | | |
| ADDRESS OF INSURANCE COMPANY | CITY, STATE, ZIP | |
| | | |
| INSURANCE COMPANY PHONE # | COPAY AMOUNT | |
| | | |
| RELATIONSHIP TO PATIENT | EFFECTIVE DATE | EXPIRATION DATE |
| | | |

I, the undersigned, certify that I (or my dependent) have insurance coverage. I assign directly to Harold A. Nord OB-GYN, S.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and any finance charges incurred on all balances over 60 days and any collection costs such as collection fees, attorney fees, and court room costs. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions and any collection processes.

Signature of Patient/Guardian_____ Date _____

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## Acknowledgment of Receipt of Notice of Privacy Practices

I, _____(print name), have received a copy of this office's updated Notice of Privacy Practices.

_____
Signature of patient or parent/legal guardian/legally responsible person

_____
Date of Birth

_____
Description of relationship to the patient

_____Date

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual/Representative refused to sign the form
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)

_____

_____

_____

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# HEALTH HISTORY SUMMARY

**Patient Name:** **DOB:** **Age:** **Date:**

☐ New Patient Married/Years_____ S W D Sep Spouse_____
☐ Consult Race_____ Religion_____
☐ Established Patient Education GED HS SC CD GD Other_____
Referring Physician/ Primary Care Physician: Occupation: (Adolescent) Lives with:

**SOCIAL HISTORY**

| | |
|---|---|
| **Smoking** | ☐ No ☐ Yes PPD History |
| **Alcohol** | ☐ No ☐ Social Drinks per week/month |
| **Street Drugs** | ☐ No ☐ Yes Notes: |
| **Exercise** | ☐ No ☐ Yes ☐ Sometimes |
| **Nutrition** | ☐ Excel ☐ Good ☐ Poor Notes: |
| **Safety** | Seatbelt ☐ Yes ☐ No ☐ History of Abuse |

**ALLERGIES** **NONE**

| | |
|---|---|
| Latex ☐ IV Dye ☐ PCN ☐ Sulfa ☐ | |
| Other: | |
| | |
| | |
| | |

**CURRENT MEDICATIONS /SUPPLEMENTS**

| | |
|---|---|
| | |
| | |
| | |
| | |

**HOSPITAL/SURGICAL HISTORY** **NONE**

| | |
|---|---|
| | |
| | |
| | |
| | |

**GYNECOLOGIC HISTORY** Last Menstrual Period: ☐ Hysterectomy ☐ BSO ☐ Menopause

| | | | | | |
|---|---|---|---|---|---|
| Age First Menses: | Menses every____ days | Length: | Amount: | **Cramps ☐ No ☐ Yes Meds** | Clots ☐ No ☐ Yes |
| Pap Smear History: ☐ Normal ☐ Abnormal Year of last Pap smear: Year of Abnormal pap: | | | | | Currently Sexually Active: Y/N |
| Method of Contraception: | | | | | Total # of past sexual partners: |

**PREGNANCY HISTORY** **NONE**

| # | Year | Sex | Weight | Weeks | Type of delivery | Pregnancy or Delivery Complications |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |

**PERSONAL/FAMILY HISTORY** Patient Family NONE Patient Family

| | | | | | | |
|---|---|---|---|---|---|---|
| Birth Defects/Genetic Disorders | | | | Pulmonary problems | | |
| Diabetes | | | | Kidney- urinary problems | | |
| ↑ Cholesterol | | | | Musculoskeletal problems | | |
| High Blood Pressure | | | | Vein Problems | | |
| Stroke | | | | Anemia/Bleeding problems | | |
| Heart Disease | | | | Blood Transfusions | | |
| Thyroid Disorders | | | | Infectious diseases | | |
| Osteoporosis/Osteopenia | | | | Tuberculosis | | |
| Seizure Disorders | | | | STDs | | |
| Autoimmune Disorder | | | | Rheumatic fever | | |
| Mental Disorders | | | | Infertility | | |
| Endometriosis/Other History | | | | Other History | | |

**CANCER HISTORY** **NONE** **RELATIONSHIP**

| | |
|---|---|
| Female (breast, ovarian, uterine, cervical) | |
| Other (colon, skin) | |

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# Patient Authorization for Use & Disclosure of Protected Health Information and Notification of Test Results

I _____ give my permission to release my medical information and lab results to the following persons only:

| Name | Relationship |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Primary Care Physician _____
Do you want our office to notify you if results are normal? Yes ___ No ___
Phone number to contact you with your results: _____
Would you like messages to be left with results? Yes ___ No ___

**Please be aware that our office will contact you with all abnormal results. Please contact our office if you have not been notified of your test results within 14 days.**

Print patient name: _____ Date of Birth: _____
Signature of patient: _____
Today's date: _____

***This information will remain in effect, until revoked in writing, by patient.***