



Heart of Illinois Obstetrics & Gynecology

1302 Franklin Ave., Suite 2800, Normal, IL 61761 • 309-454-3456

Thank you for scheduling an appointment with our office. It is our pleasure to welcome you to Heart of Illinois OB-GYN 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 & Dr. Jared Zotz



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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.

If you are covered by **two separate insurance policies**, it is your responsibility to contact both to set up Coordination of Benefits (COB), prior to your appointment. Inform Check-In personnel as to which policy is primary and which is secondary to ensure that your insurance is billed properly.

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	EMAIL ADDRESS		
PRIMARY CARE PHYSICIAN	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 Heart of Illinois OB-GYN 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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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 note, if you are currently pregnant and your lab results are normal, results will be discussed at your next prenatal visit. Feel free to call the office if you desire to discuss your results prior to your scheduled appointment.

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.



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 Phone: 309-454-3456 Fax 309-454-6977

HEALTH HISTORY SUMMARY

Patient Name:	DOB:	Age:	Date:
<input type="checkbox"/> New Patient	Married/Years _____ S W D Sep	Spouse/Significant Other _____	
<input type="checkbox"/> Consult	Race _____	Religion _____	
<input type="checkbox"/> Established Patient	Education GED HS SC CD GD Other _____		
Referring Physician/ Primary Care Physician:		Occupation:	(Adolescent) Lives with:

SOCIAL HISTORY	
Smoking	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Former Smoker PPD Vaping Y or N
Alcohol	<input type="checkbox"/> No <input type="checkbox"/> Social Drinks per week/month
Street Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes Notes:
Exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Days per Week
Nutrition	<input type="checkbox"/> Excel <input type="checkbox"/> Good <input type="checkbox"/> Poor Notes:
Safety	Seatbelt <input type="checkbox"/> Yes <input type="checkbox"/> History of Abuse

ALLERGIES	NONE
Latex <input type="checkbox"/> IV Dye <input type="checkbox"/> PCN <input type="checkbox"/> Sulfa <input type="checkbox"/>	
Other:	

CURRENT MEDICATIONS / SUPPLEMENTS	

HOSPITALIZATION/SURGICAL HISTORY (please list procedure/hospitalization and year)	
<input type="checkbox"/> NONE	

GYNECOLOGIC HISTORY Last Menstrual Period: _____		<input type="checkbox"/> Hysterectomy		<input type="checkbox"/> BSO		<input type="checkbox"/> Menopause	
Age First Menses:	Menses every _____ days	Length:	Amount:	Cramps: <input type="checkbox"/> No <input type="checkbox"/> Yes	Meds:	Clots: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Pap Smear History: <input type="checkbox"/> Normal <input type="checkbox"/> 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 Member	None	Patient	Family Member	None
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	Family Member/age of diagnosis/living or deceased	<input type="checkbox"/> NONE
Female (breast, ovarian, uterine, cervical)		
Other (colon, skin)		