New Dawn
Wellness Group

5851 W. 95th Street, Ste. 400 Oak Lawn, IL 60453
10762 W. 167th Street Orland Park, IL 60467
(708) 581-7950
(708) 425-5779 FAX
www.NewDawnWellnessGroup.com

Welcome to our office and thank you for choosing us as your healthcare providers. Our highly qualified providers and staff are committed to doing everything possible to provide you with excellent care and make your visit to our office pleasant and comfortable. Our hope is that together we develop a partnership to keep you as healthy as possible, no matter what your current state of health.

We currently have one Licensed Clinical Professional Counselor, Kathryn Gardner. If you wish to see a medical provider with Women's Care Group, there are currently five providers in the office: three physicians and two advanced nurse practitioners. The providers will consult and collaborate your care as needed. Please be aware that one weekend per month, Dr. Nancy Church and Associates is on call for our group to give us 2 days completely off per month.

The following guidelines are set up to guarantee patient care and provide the safety and welfare of all patients:

Contacting the Providers for Emergencies- The front office staff are available during regular business hours to schedule and reschedule appointments. The billing department is available during regular business hours to discuss your finances. If you have an emergency after hours and need to reach your Therapist, please call the main health provider's office at (708) 857-7230. Your call will be directed to the answering service of a medical provider and transferred to your Therapist if necessary. After the provider is paged, you should receive a call back within 30 minutes. In the unlikely event that you do not receive a return phone call within 30 minutes, please have us paged again. If you do not receive a phone call within 60 minutes, please go to the emergency room. If you have general questions, or non-emergent concerns after office hours, please feel free to call the office the next business day and our staff will be happy to assist you. If you choose to have the providers paged for non-emergent reasons, there will be a $25.00 service fee processed to your account.

Missed Appointment Fees- It is very important that you attend every scheduled appointment so that we can provide you with the best possible care. Cancellations and/or changes need to be made at least 24 hours prior to your appointment time. Failure to do so will result in a $100.00 missed appointment fee. If you miss your appointment due to an emergency, we will waive the fee.

Confidentiality – All treatment is confidential and private. The exceptions to confidentiality include, but are not limited to, when a patient is a harm to self or to others. Therapists are mandated reporters and must follow the protocols for reporting suspected child or elder abuse or neglect. Therapists must follow necessary legal requests for patient information.

Medical staff are available should your care necessitate a consult or to set-up an appointment.

If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time they are rendered. We accept cash, check, Visa or MasterCard for payments. We will be happy to process any insurance claims for you and we do accept insurance assignment. We will do our very best to accurately ***estimate*** what your insurance company will pay toward normally covered services. Please understand, however, our calculations are strictly an estimate and are no guarantee that your insurance company will reimburse us according to these estimates. Ultimately, your insurance is contracted between you and your insurance carrier. We are not a party to that contract. Any service that is not covered by your insurance company, for whatever reasons, is your financial responsibility.

Returned checks, NSF fees, and balances older than 30 days will be subject to additional collection fees and interest charges of 1.5% per month. A charge of $100.00 may also be assessed to your account for missed appointments or appointments cancelled without 24 hours advance notice. **Any attorney or collection fees incurred due to delinquency in payment will be charged to the patient**.

Payment is always due at the time services are rendered.

☐ By checking this box and signing below, I hereby acknowledge that I have read this document and understand my financial responsibility for services provided for me and other patients whose names I have provided and appear on my account.

_____ _____

Signature Date

Thank you for choosing our office. In order to serve you properly please print all information below. This information is required and will be kept confidential. Failure to fill out information may cause delays in payment from your insurance company, making you responsible for all charges.

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Name _____ **Date of Birth**_____

Address_____ **Apt #** _____ **City** _____**State** ____ **Zip Code** _____

Home Phone # _____ **Cell Phone #** _____ **E-Mail** _____

HIPAA: May we leave a detailed message on Home # (Circle One) **Yes** **No**
HIPAA: May we leave a detailed message on Cell # (Circle One) **Yes** **No**

Marital Status (Circle One) **Married** **Widowed** **Single** **Divorced**

Social Security # _____-_____-_____**Driver's License #**_____

Employer Name _____ **Employer Phone #** _____ **Occupation:**_____

Emergency Contact Person_____ **Relationship**_____ **Phone#** _____

Whom may we thank for referring you? _____

If not being referred, how did you hear about us? _____

Responsible Party-Insurance Holder (Subscriber) Information

☐ **Please check this box if the patient is the insurance subscriber and this information is the same as above.**

Primary Insurance: _____

Name of Insured_____ **Relationship to Patient:** _____**Date of Birth** _____

Address_____ **Apt #** _____ **City** _____**State** ____ **Zip Code** _____

Home Phone # _____ **Cell Phone #** _____

Social Security # _____-_____-_____ **Driver's License #**_____

Employer Name _____ **Employer Phone #** _____

Secondary Insurance _____

If yes complete the following; Insurance Company_____

Name of Insured: _____ **Relationship to Patient**_____ **Date of Birth**_____

SSN_____-_____-_____ **Home Phone #**_____ **Work Phone#**_____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the Doctor, realizing I am responsible to pay any non-covered service.

_____ _____
Signature Date

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ **Home Telephone**

Number _____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐ **Written Communication**

☐ OK to mail to home

☐ OK to email

☐ **Work Telephone**

Number _____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐ **Cellular Telephone**

Number _____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐ OK to text

Release of Medical Information

Please list any person or persons whom we may discuss about your medical information or appointments.

Name	Relationship	Medical Information	Make, change or cancel appointments
		Yes or No	**Yes or No**
		Yes or No	**Yes or No**

_____ _____

Patient Signature Date

_____ _____

Print Name Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

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Patient Acknowledgement Form

I have received the Notice of Privacy Practices, the HIPAA forms and the Patient Bill of Rights. I have been provided an opportunity to review it.

Print Name _____ Birth date_____

_____ _____

Signature Date

Patient's Name _____ Date _____

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What brings you in today?

(Do you have or have you ever had)

- ☐ Mood changes
- ☐ Depression
- ☐ Anxiety
- ☐ Worry
- ☐ Change in sleep
- ☐ Over-sleeping
- ☐ Disrupted sleep
- ☐ Feel like you are running on a motor
- ☐ Restless
- ☐ Isolation from others
- ☐ Fatigue
- ☐ Low energy
- ☐ Crying spells
- ☐ Low motivation
- ☐ Loss of interest
- ☐ Change in appetite
- ☐ Weight gain
- ☐ Weight loss
- ☐ Panic attacks
- ☐ Difficulty focusing
- ☐ Feel overwhelmed
- ☐ Palpitations
- ☐ Sweating
- ☐ Fear you are losing control
- ☐ Dizziness
- ☐ Hot spells
- ☐ De-realization
- ☐ Racing thoughts
- ☐ Intrusive thoughts/images
- ☐ Obsessions
- ☐ Compulsions
- ☐ Checking behaviors
- ☐ Perfectionism
- ☐ Body image issues
- ☐ Extreme dieting
- ☐ Binge, purging
- ☐ Nightmares
- ☐ Flashbacks
- ☐ Hypervigilance
- ☐ Irritability
- ☐ Anger
- ☐ Avoidance
- ☐ Acting out/impulses
- ☐ Increased substance abuse
- ☐ Self injury
- ☐ Thoughts to harm self
- ☐ Thoughts to harm others
- ☐ OTHER:

Comments:

Recent Stressors

(Last 12 months – check all that apply)

- ☐ Aging parents
- ☐ Infidelity
- ☐ Medical termination
- ☐ Divorce/Separation
- ☐ In-law issues
- ☐ Menopause
- ☐ Elective termination
- ☐ Issues at home
- ☐ Miscarriage
- ☐ Empty nest
- ☐ Issues at work
- ☐ Move to a new home
- ☐ Fertility issues
- ☐ Issues at school
- ☐ Parenting issues
- ☐ Financial stress
- ☐ Job change
- ☐ Pregnancy
- ☐ Health issues -self
- ☐ Lack of support system
- ☐ Relationship conflict
- ☐ Health issues – family member
- ☐ Legal issues
- ☐ Remarriage
- ☐ Hospitalization - medical
- ☐ Loss of a loved one
- ☐ Reproductive issues
- ☐ Hospitalization – mental health
- ☐ Loss of employment
- ☐ Retirement
- ☐ Identity issues
- ☐ Major life transition
- ☐ Sexuality issues
- ☐ Infant Loss
- ☐ Marital issues
- ☐ Spiritual issues
- ☐ Infertility - self
- ☐ Medical concern in pregnancy
- ☐ Stillbirth
- ☐ Infertility - partner
- ☐ Medical concern for baby
- ☐ Traumatic event
- ☐ OTHER:

Comments:

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Reproductive & Menstrual History

☐ **NONE**

Total # of Pregnancies	Total # of Full Term Deliveries	Total # of Premature Deliveries	Total # of Multiple Births
Total # of Terminations	**Total # of Miscarriages, Stillbirths**	**Total # of Ectopic Pregnancies**	**Total # of Children Living**

Date of Delivery	Child's Name

Infant Loss: YES NO Child's Name_____

Dates of IUI	
Dates of IVF	
Medications taken for fertility	
Onset of Perimenopause	
Onset of Menopause	

Medications

☐ **NONE**

Name of Medication Currently Taking	Dosage	Frequency	Reason for Taking

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Compulsive Behaviors

Yes	No		Please give details
☐	☐	Alcohol	_____
☐	☐	Illegal Drugs	_____
☐	☐	Prescription pills	_____
☐	☐	Over-eating	_____
☐	☐	Gambling	_____
☐	☐	Over-spending	_____
☐	☐	Other	_____

Family History

Yes	No		Relationship
☐	☐	Depression	_____
☐	☐	Anxiety	_____
☐	☐	OCD	_____
☐	☐	Panic disorder	_____
☐	☐	Bipolar	_____
☐	☐	ADHD	_____
☐	☐	Alcoholism	_____
☐	☐	Substance abuse	_____
☐	☐	Other	_____

Previous Treatment

Yes	No		Dates
☐	☐	Inpatient Mental Health	_____
☐	☐	Substance Abuse Treatment	_____
☐	☐	Partial Hospitalization Program	_____
☐	☐	Individual Counseling	_____
☐	☐	Couples Counseling	_____

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Dear Patient,

The following are our financial office policies and procedures.

Registration: In order for us to properly bill your insurance carrier all information requested is to be filled out properly & completely. Failure to fill in areas requested can delay or cause denials from your insurance company.

Co-Pays: Co-pays are always due at the time of service. Our office policy is not to bill you for your copays, since they are due at the time of service. If you ask our staff to bill you for your copay there will be a $10.00 service/processing fee. We accept cash, check, Visa and MasterCard.

Insurance Cards: **Current insurance cards are required at every visit**. If there are any changes to your insurance, including but not limited to, new insurance member identification number and/or group number, please inform the front desk at the time of check in and provide the updated card. If you are not the primary card holder, all information regarding the primary card holder is required to be filled out in full. Failure to fill in area can delay or cause denials or no payment from your insurance carrier. If this happens you may be asked to pay for all charges in full since we will not rebill your insurance carrier.

If you have not provided our office with the correct insurance information, you will be responsible for any balance due. We are unable to re-submit insurance claims.

Change in Personal Information: Please inform the front desk of any change in personal information by calling or writing the office at your earliest convenience. This includes, but is not limited to, change of address, telephone number, or last name. Failing to update personal information can delay communication regarding your health information.

Self-Pay Patients: If you do not have insurance, payment for your visit is due at the time of service. We accept cash, check, Visa and MasterCard. If you are a NEW PATIENT and are a self-pay, we will accept cash or credit card only.

Appointment Times: Please try to make every effort to notify our office if you will be arriving late. New patients should show up 15 minutes before your scheduled appointment time. If you arrive after your scheduled appointment time, we will need to reschedule your appointment or we may ask that you wait until the next open spot on the schedule while we continue to see the patients who have arrived on time.

Missing an Appointment: We ask for 24 hour notice when canceling an appointment. A $100 missed appointment fee will be assessed to your account if 24 hour notice is not given when canceling or rescheduling an appointment; this includes but is not limited to missing your appointment for not having a current insurance card. Our office understands that emergencies do happen and for certain circumstances, the fee will be waived.

Workman's Compensation: If your visit will not be submitted under your insurance plan, our office must have all necessary claim information before or at the time of your visit. If we are not provided with the correct information then you will be personally responsible for outstanding account balances.

Insurance & Employer Paperwork: An appointment may be required to have forms completed. Our office charges $25 for all forms completed. This fee will be collected at the time forms are submitted.

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Billing Statements: Our office sends out bi-weekly billing statements to every patient with an outstanding balance. This balance usually reflects the remainder owed after your insurance has paid. It is your responsibility to pay your statement balance even if you and your insurance company are disputing coverage.

Collections: If your account balance is unpaid and overdue after three statements or more and we have been unable to contact you, your account will be referred to a collection agency. Any and all fees associated to your account being sent to a collection agency will be your responsibility. Our collection company does charge a 30% fee for all accounts sent to collections, this fee will be the patient's responsibility to pay. Once your account is in collections, we will be unable to make any future appointments for you. Please note, we will only proceed to these measures if you do not respond to our attempts to communicate with you or set up a payment plan.

Payment Plans: If you have negotiated a payment plan with us, you are responsible for making timely and consistent monthly payments. We offer payment plans as a courtesy to our patients in time of need. Please understand that we are not a bank or a financial institution and our payment plans are for a short time period, normally arranged to be paid off within 6 months. If you fail to make your scheduled weekly/bi-weekly or monthly payment and do not contact our office or respond to our attempts to contact you, your account will be sent to collections for non-payment.

After Hours Calls: Our office has a provider on call when the office is closed. This provider is to be called for emergencies only. A refill for a prescription is not usually considered an emergency and we ask that you have a refill request faxed to our office by your pharmacy. We will do our best to refill your prescription in a timely matter.

Medical Records: All requests by patients must be signed and in writing either by letter, fax, or a medical release of information form. Verbal requests will not be honored. A request is not necessary if the information is shared with a physician we have referred you to.

Copying Fees: Should you need your medical records copied, fees may apply.

Diagnosis Codes: Our office cannot recode an office visit because your insurance does not cover certain visits; this is illegal and considered fraud. It is your responsibility to know what your insurance plan covers. Always call your insurance company to verify coverage. It will be your responsibility to pay any unpaid amount that your insurance does not cover within 30 days.

Test Orders, Referrals and Follow-Up Care: Our office tracks test orders and referrals given to patients, as well as expected follow up care. An expected time frame for completion of these tests is assigned. If we have not received a report within the expected timeframe, you may receive a call or letter reminding you of the recommendation and the reason for the recommendation. We ask that you please respond with your intent to follow-up within a timely manner after receiving the reminder. Lack of response by the patient will be interpreted by the office that the patient assumes sole responsibility for the consequences of their inaction on this matter. Noncompliance could result in being discharged from the practice.

Uncooperative Patients: Physicians and staff members are not required to continue treatment of a patient who is uncooperative, refuses to follow treatment advice and presents difficulties in the doctor-patient relationship. Our goal is to try to accommodate all of our patients' needs to the best of our ability. Demanding and abusive language does not help us achieve that goal. Patients may be dismissed from our practice for this behavior.

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Thank you for your cooperation!

☐ By checking this box I certify that I have read the above information and agree to follow the office policies and financial procedures of Women's Care Group and New Dawn Wellness Group. I understand that if I do not follow these policies and procedures, I may be dismissed from the practice.

_____ _____

Print Name Date

_____

Patient Signature