South Lake Women's Health, PC
11376 Broadway
Crown Point, IN 46307

Welcome to South Lake Women's Health. Our professional staff is readily available to meet your medical needs. The business office is able to assist you in meeting the financial obligations which go along with medical care. It is our office policy to receive payment in full at the time of service.

Payment is requested for all office services AT THE TIME SERVICES ARE RENDERED for those patients who are paying with cash. For your convenience we accept cash, check, MasterCard and Visa. If you have insurance and we do not participate with that insurance, we will provide the necessary information for you to file so you may be reimbursed by your insurance company. Please provide the receptionist with your current insurance card at the time of your office visit to avoid delay in filing claims.

Medicaid / Medicare:
WE ARE NOT A PARTICIPATING PROVIDER WITH THESE PLANS.

HMO/PPO:
Patients who are members of HMO's and PPO's may be required to pay a co-payment. Co-payments are due AT THE TIME THE SERVICE IS RENDERED. We are participants with Blue Cross & Blue Shield, Anthem, Aetna, Principal Life, Private Health Care Systems and Sagamore and other programs. All insurance claims will be filed for patients who are participants in these programs.

Other Insurance:
Insurance will be filed for all services provided. It is important for the patient to provide the correct information for filing. Not all insurance plans pay the same benefits or apply the same deductible, thus there may be a balance due after insurance has paid. Since the insurance contract is an agreement between you and your insurance company, any unpaid balance will remain the responsibility of the patient.

We send out all specimens/labs to Lab Corp. If your insurance requests that certain labs be used, please notify our office. We will try to accommodate your needs.

Please advise our insurance biller if your insurance company has special requirements such as pre-certification or second opinions. We do all we can to help, but the ultimate responsibility for fulfilling special requirements rests with the patient.

Statements:
Every effort is made to avoid the cost of having to mail statements. Statements are mailed to those patients with balances due and payment is due upon receipt.

Our intention is to manage the financial business of medical care in the spirit of understanding and cooperation. We hope this provides you with the basic information needed concerning our payment structure. If you have any further questions, please feel free to contact our office.

If it becomes necessary to employ a collection agency, service or attorney to enforce payment, you agree to pay for the costs and the fees charged for such service, including but not limited to attorney's fees and the cost of court proceedings through judgment and execution of judgment and appeal.

Responsible Party Signature: _____ Date: _____

Name _____ □Miss □Mrs. □Ms. □.Dr
DOB_____ Age_____ Mart Sts: S M D W
Ht: _____ Wt._____ BP _____ T _____P_____ BMI _____

Gynecological History:
Number of Pregnancies _____ _____
Number of Births _____ □Vaginal □ C-section

Contraceptive method:
□none □Not Applicable □ Tubal Ligation □Vasectomy _____
□ IUD □ Rhythm □Withdrawal □Diaphragm
□ condoms □Spermicide □ BC patch/ring/pill □ Depo Provera

Are your sexual partners? Male Partners□ Female partners□ □Both □None _____

Please fill in the date of your last pap test and whether it was normal or abnormal? _____
Pap Date_____ □Normal □Abnormal _____

Have you ever had an abnormal pap? □No □Yes If yes, what year?_____ _____

Mammogram Date_____ □ Normal □Abnormal □Never Had _____

Dexa Scan (bone density testing) date_____ _____
□Never Had □ Normal □Osteopenia □Osteoporosis _____

Menstrual history:
Last menstrual period :_____(first day of last period) _____
Age when you had your first period_____ _____
Date when you stopped having periods_____ □Not Applicable _____
Menstrual Cycle: Days_____ Duration _____ Clots □ïYes □No Painful periods □Yes □No

When was date of last colonoscopy? _____ □Never Had_____

Please list any surgeries:

Year	Procedure	Year	Procedure
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any medical conditions for which you have received treatment including current medical conditions:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all medications you are currently taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Risk Summary

Do you have a family history of:
□Heart Attack □Breast Cancer □Uterine Cancer _____
□Heart Disease □Ovarian Cancer □Other Cancer_____ _____
□High Blood Pressure □Diabetes _____

Do you have a medical condition which requires you to take antibiotics at the dentist? □Yes □No _____

Do you have any of the following? _____
□Artificial Joints, if so what joints_____ _____
□Transplants, if so what organs_____ _____
□Mitral valve prolapse _____

Do you have any allergies to any drugs or medications? □No □Yes _____

If yes, please list drug and type of allergic reaction: _____

Drug	Reaction	Drug	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

The following questions assess risk of cervical cancer and are diagnostic codes for pap smears:

Did you have intercourse before you were 16 years old?	No	Yes	V15.89	_____
Have you had more than 5 sexual partners in your lifetime?	No	Yes	V15.89	_____
Have you ever had a sexually transmitted disease or infection?	No	Yes	V15.89	_____
Do you have HIV?	No	Yes	V15.89	_____
Have you had fewer than 3 normal pap smears in the last 7 years?	No	Yes	V15.89	_____
Do you smoke?	No	Yes	# of cigarettes per day_____	

Number of alcoholic drinks per day_____ Per week_____

Do you use recreational or illicit drugs	No	Yes	_____
Are you being abused or have you been abused?	No	Yes	_____
			_____
Do you exercise?	Yes	No	_____
# of times per week_____			_____
Length of exercise workouts_____			_____
Intensity □Mild □Mod □High			_____

Review of Systems:
Are you having any problems with?

Weight Loss/Gain	NO	YES	_____	Skin Rashes	NO	YES	_____
Fever	NO	YES	_____	Leg Swelling	NO	YES	_____
Vision	NO	YES	_____	Seizures	NO	YES	_____
Hearing	NO	YES	_____	Headaches	NO	YES	_____
Sore Throat	NO	YES	_____	Depression / Anxiety	NO	YES	_____
Chest Pain	NO	YES	_____	Hot Flashes	NO	YES	_____
Breathing	NO	YES	_____	Bleeding	NO	YES	_____
Coughing	NO	YES	_____	Urination	NO	YES	_____
Stomach Pain	NO	YES	_____	Urine Loss	NO	YES	_____
Joint Pain	NO	YES	_____	Intercourse	NO	YES	_____
Vaginal Discharge	NO	YES	_____	Pelvic Pain	NO	YES	_____
Itching, Burning	NO	YES	_____	Change in Periods	NO	YES	_____
Breast Lump / Discharge	NO	YES	_____	Personal History of HIV	NO	YES	_____

Other:_____

Please list any issues you would like to discuss:
_____
_____
_____
_____

Physician: Dr Pamela Seaman_____ Dr Merit Lemke _____

Nurse/MA _____ Date:_____

FP/IM_____ Consult requested by:_____

Pap Results
You will receive a piece of paper that will contain the collection date of your pap smear, along with the phone number to the LabCorp Pap Testing Patient Information Line, as well as directions for obtaining your pap results. If you are told that your results are abnormal and you need to contact your Physician, please do so in a timely manner, so we can make the necessary follow up arrangements.
Please initial_____

Mammogram results
Patients go to several different facilities to have mammograms done. The facility (at which the mammogram was done) is required to inform the patient of mammogram results. South Lake Women's Health will also receive a copy of your mammogram result and will file the result in your chart. To discuss your mammogram results please call 663-1880 to make an appointment. Within one month, if you have not received you results from the facility in which you chose to have you mammogram done, please call our office. We will need the date the test was done and the location so that we can call to obtain the results.
Please initial_____

Ultra Sound and/or Dexascan results
Patients go to several different facilities to have an Ultra Sound and/or a Dexascan (Bone density) done. South Lake Women's Health should receive a copy of your results. A card will be sent to you indicating your results. If you do not receive a card or a call within one month of having an Ultra Sound and/or Dexascan test done, please call our office at 663-1880, we may not have received your results from the testing facility. We will need the date the test was done and the location so that we can call to obtain the results.
Please initial_____

Blood test
Patients go to several different facilities to have a blood test done. South Lake Women's Health should receive a copy of your blood test result. A card will be sent to you indicating your results. If you do not receive a card or a call from the office within two weeks of having the Blood test done, please call our office at 663-1880, we may not have received your results from the testing facility. We will need the date the test was done and the location so that we can call to obtain the results.
Please initial_____

Urine and all other cultures
Patients go to several different facilities to have cultures done. South Lake Women's Health should receive a copy of your culture result. A card will be sent to you indicating your results. If you do not receive a card or a call from the office within two weeks of having the culture done, please call our office at 663-1880, we may not have received your results from the testing facility. We will need the date the test was done and the location so that we can call to obtain the results.
Please initial_____

Screening Tests
We give you a requisition when we order routine health maintenance screening tests . We will not follow up to see if these tests have been done. It is your responsibility to complete these tests.
Please initial _____

My signature acknowledges that I have read the above information, I have had all of my questions answered concerning the above information, I have no further questions and understand the above information. I have received a copy of this notice.

Signature_____ Date_____

Revised 09-26-06

Patient Financial Agreement Form

Welcome to South Lake Women's Health, P.C. Our professional staff is committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to receiving treatment.

Authorization

I hereby authorize the release of pertinent medical information to my insurance carriers, and I agree to assignment of benefits to the physician. I am aware that the health insurance coverage varies and, while insurance carriers may use terms such as customary, reasonable, prevailing, etc. to limit their coverage, I am ultimately responsible for payment of all charges for services rendered by the physicians of South Lake Women's Health, P.C. and any other charges for laboratory fees, radiology fees, and any other fees as a result of the treatment rendered. If I have insurance that the doctors are contracted with, I understand that I will be responsible for any co-payments, deductibles, co-insurance, or any services that are not considered medically necessary by my insurance company.

Finance Charges

I understand and agree that there will be a late fee added to my account if I fail to pay within thirty (30) days from my first statement. The late fee charge will be $25.00. I understand that I am solely responsible for this late fee and that it will not be billed to my insurance.

I understand that a finance charge will be imposed for patient due balances after January 1, 2004, which has not been paid within 30 days of the time of service. The finance charge will be computed at the rate of one percent (1%) per month unless alternate arrangements have been made.

Returned Checks / Clerical Fees

I understand that if the bank returns a check there is a $29.00 processing fee that will be added to my account. I understand and agree that I will be billed $1.00 for the first 10 pages and $.50 for 11-50; $.25 for pages 51 and higher.

Late Cancellation / Missed Appointment

I agree to pay a fee of $25.00 if I fail to either cancel an appointment 24 hours prior, or fail to show up for a scheduled appointment.

Attorney Fees

In the event that I fail to pay the balance of my account to South Lake Women's Health, P.C. within sixty (60) day of the date of service, my account will be turned to collection. In the event that it is necessary to turn my account over to collection I will also be responsible for any and all costs of collection, including attorney fees and interest charges.

Authorization & Release

I have read and fully understand the Patient Financial Agreement as outlined above. I have also been given a copy of the Patient Financial Agreement for reference.

I understand that this Authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this date forward until it has been revoked in writing.

_____ _____

(Patient Signature) (Date) (Patient Printed Name) (Date)

Signature for Receipt of Patient Privacy Notice

I acknowledge that I have received a copy of the Patient Privacy Notice for South Lake Women's Health, P.C., office of Drs. Pamela Seaman and Merit Lemke.

I understand that my signature only represents my receipt of this Notice.

Print Name: _____

Address: _____

_____

Birth Date: _____/_____/_____

X _____

Patient Signature (Parent or Guardian must sign for minors)

Print Parent or Guardian name: _____

Please advise if there are any family member(s) with whom we may leave messages or discuss your medical record with:

_____ _____

(name) (relationship to patient)

_____ _____

(name) (relationship to patient)

_____ _____

(name) (relationship to patient)

_____ _____

(name) (relationship to patient)

Office use only:

Patient not present *Patient refused to sign*

Entered acknowledgement into the computer system by: _____

South Lake Women's Health

Dear Patient:

At our practice we pride ourselves on offering our patients the most advanced preventative care available. We now offer our patients the only FDA-approved high-risk HPV test. This new test is a highly sensitive viral test used in conjunction with a Pap test for cervical cancer screening in women aged 30 and older. Persistent infection with high-risk human papillomavirus (HPV) is the primary cause of cervical cancer. A few important things to know about HPV and cervical cancer screening:

- Most women will have HPV at some point during their lives, but very few will develop cervical cancer.
- Cervical cancer develops if an HPV infection persists for many years.
- The Pap test looks for abnormal cell changes on the cervix that occur as a result of a persistent high-risk HPV infection. The HPV test looks for an HPV infection.
- When used together, these tests can show with nearly 100% certainty that you do not have cervical disease. Women who test negative for high-risk HPV, and have a normal Pap test, have virtually no risk of developing cervical cancer before their next scheduled visit.
- Knowing your HPV status helps you and your provider determine how often you should be screened. Early detection of pre-cancerous cell changes is the key to preventing cervical cancer.
- Your HPV status is not a reliable indicator of you or your partner's sexual behavior. HPV can lie dormant in cervical cells for many years before becoming an active infection.

Most insurance companies cover the high-risk HPV test when used with a Pap test for cervical cancer screening of women 30 or older. However, the individual benefits you or your employer purchased may or may not cover the test. If the test is not paid for by your insurance company, you will receive a bill from the laboratory. The cost is approximately $150 – $250.

☐ I have read the above information and **AGREE** to have the screening HPV test with my pap Test. I also agree to pay for the HPV test should my insurance not cover the cost.

☐ I have read the above information and **DO NOT** wish to have the **Screening** HPV test done. If your Pap smear is **abnormal**, a **Diagnostic** HPV Test maybe automatically indicated, and therefore will need to be performed.

X_____ Date: _____
Patient Signature

_____
Patient Name (please write legibly)