

Welcome to Women's Cancer Care Associates

We're honored you've chosen us to be part of your care. Inside this packet, you'll find your new patient paperwork. Please complete it as thoroughly as you can—and bring it with you to your visit, along with the following:

- A list of your current medications, including names and dosages (or the bottles themselves)
- Any questions you'd like to ask about your diagnosis or upcoming care
- Your insurance card(s) and a valid photo ID

What to Expect at Your First Visit

This first appointment is a consultation—not a surgery—so feel free to eat, drink, and take your regular medications beforehand. Your provider may need to perform a physical exam, so we recommend dressing in comfortable clothing and being prepared just in case.

Coming in prepared helps us give you the best care possible—and can ease any anxiety you may feel before your visit. You know your body best. We're here to listen.

Insurance and Payment

Our office receives your insurance information from your referring provider and will verify it ahead of your appointment. If we're unable to verify coverage—or if your insurance is inactive—you'll be responsible for a \$300 consultation fee, payable at check-in. We accept cash or check (preferred), as well as credit cards.

Please note: a 3% surcharge applies to all credit card transactions.

Need to Reschedule?

We understand life doesn't always go as planned. If you need to cancel or reschedule, please call us at least **48 hours in advance at 708.375.2505**. This allows us to offer the appointment to someone else in need of care.

Missed appointments without notice will incur a **\$50 no-show fee**, and any future appointments may require physician approval to reschedule.

We're here to support you every step of the way. If you have any questions before your visit, don't hesitate to reach out.

Warmly,



Rajul Kothari, MD

Women's Cancer Care Associates

Patient Information

Name: _____ DOB: _____ Age: _____

Address: _____

SSN: _____ Email Address: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Can we leave a message? No Yes If yes, check Cell Home Work Other _____

Employer's name & address: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Referred by: _____

Address and phone of referring physician _____

Primary Care Physician: _____

Address and phone of primary care physician _____

Pharmacy address, phone: _____

Do you have an Advanced Directive? No Yes (if Yes, please provide a copy)

Primary Insurance

Company: _____ Phone: _____

Policy Holder: _____ DOB: _____ Relation: _____

Policy/Member Number: _____ Group Number: _____

Secondary Insurance

Company: _____ Phone: _____

Policy Holder: _____ DOB: _____ Relation: _____

Policy/Member Number: _____ Group Number: _____

To the best of my knowledge, all the information provided is true and correct.

Patient/Responsible Guardian Signature: _____ **Date:** _____

Consent for Care and Financial Agreement

CONSENT FOR CARE AND TREATMENT:

I consent to receiving outpatient services and routine medical care, which may include, but is not limited to examination, testing, and treatment, laboratory procedures, imaging examinations, medications, and therapeutics, and/or minor office procedures that my physician Dr. Rajul Kothari, MD d/b/a WOMEN'S CANCER CARE ASSOCIATES may deem necessary or advisable for myself or the patient named on this form. I understand that other healthcare providers including medical assistants and nurses, while under supervision, participate in my treatment, and I consent to such involvement in my care.

I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made concerning the results of any proposed treatments.

Rajul Kothari, MD IS NOT A HOSPITAL EMPLOYEE

You may see Dr. Kothari at one of two clinic locations: Oakbrook Terrace and/or River Forest, IL. I acknowledge, understand, and agree that while I (or the patient) may receive care and treatment at a clinic located on the grounds of West Suburban River Forest Medical Campus Building, Rajul Kothari, MD is not employed by, paid by, or under the control of West Suburban Medical Center.

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION:

I consent to the use and disclosure of my Protected Health Information by Women's Cancer Care Associates for purposes of treatment, payment, continuity of care, and other health care operations. The health information disclosed may include medical conditions, medication history, test results and treatments. I grant permission for Women's Cancer Care Associates to mutually exchange information with referring physician(s) and/or their associates. Please see the form entitled Notification of Privacy Practices for more details.

ASSIGNMENT OF BENEFITS AND INSURANCE AUTHORIZATIONS:

I hereby authorize Women's Cancer Care Associates to furnish information to insurance carriers concerning my medical condition and treatment. I hereby assign all payments for medical services rendered to me. I understand that I am responsible for all services not covered by insurance.

MEDICARE/MEDICAID AUTHORIZATION:

I request that payment for authorized Medicare/Medicaid benefits be made on my behalf to Women's Cancer Care Associates for services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

FINANCIAL AGREEMENT:

In consideration for services rendered by Women's Cancer Care Associates, I guarantee timely payment for all such services not paid by insurance carriers or third parties. I understand that any amounts not covered by my insurance or other third-party payor are my personal responsibility, and I agree to make payment for any such amounts. If Women's Cancer Care Associates does not receive payment, the bill may be turned over to an attorney or a collection agency and, if so, I agree to pay all reasonable collection costs including attorney's fees and/or collection fees in addition to the amount owed.

I hereby agree that I am financially responsible for all charges incurred on behalf of the patient.

I also understand that any deductible, co- insurance, or co-payment is due at the time services are rendered. I authorize the office to file my insurance on my behalf. I authorize the release of any medical information necessary to process a claim. If for any reason the insurance company will not pay for charges, I understand that I am financially responsible for the payment of those charges. If the account is turned over to a collection agency and/or attorney, I will pay all incurred costs including interest charges and/or attorney's fees. **Signature is required from both the patient and legal guardian if patient is under the age of 18.**

REVOCACTION

This consent may be revoked by in writing at any time, except to the extent of the actions already taken in reliance on the consent given.

ACKNOWLEDGEMENT

My signature below constitutes my acknowledgment and agreement that I have read and understand the following forms that have been provided by Women's Cancer Care Associates:

NOTIFICATION OF PRIVACY PRACTICES

CONSENT FOR CARE AND FINANCIAL AGREEMENT

I have received a copy of these agreements and have noted the Notification of Privacy Practices can also be found online. I was given the opportunity to ask questions, any questions I asked were answered to my satisfaction.

Patient/Responsible Guardian Signature: _____ **Date:** _____

Patient Medical History

Name (First & Last) _____ Date of Birth _____

Medication Allergies: NONE YES If you indicated yes, please list below with allergic reaction:

Are you allergic to: Contrast/IV dye Latex Tape Vaccines

Mark if applicable

Medical issue	Date	Physician
Alcohol Dependence		
Alzheimer's Disease		
Anemia		
Angina / Chest pain		
Anxiety		
Asthma		
Blood disorder		
Cancer		
Cardiac arrhythmia		
Cirrhosis		
Colostomy/ileostomy		
Congestive Heart Failure		
COPD		
Coronary Artery Disease		
Depression		
Diabetes Type____		
Drug dependence Type_____		
GERD/Heartburn/Reflux		
Heart Attack		
Heart Valve Disease		
Hepatitis: Type__		
High blood pressure		
High cholesterol		
HIV/AIDS		
Inflammatory bowel disease		
Kidney Disease, Stage_____		
Organ Transplant, Type_____		
Paralysis		

	Medical issue	Date	Physician
	Parkinson's Disease		
	Pneumonia		
	Rheumatoid Arthritis		
	Schizophrenia		
	Seizure disorder		
	Stroke		
	Thyroid disease		
	Ulcer		

Other medical problems not listed above _____

Hospitalizations and Surgeries

Date	Surgery/Reason for Hospitalization	Location	Doctor

Protected Health Information – Right to Access

I give all physicians and professional staff working with Women’s Cancer Care Associates permission to disclose the protected health information set forth below to the following people at the request of one or more of these individuals.

Patient Name: _____ Date of Birth: _____

Name	Relationship to Patient	Phone Number	Information to be released	May we contact if we cannot reach you?

Note: please specify what information may be released: Complete Medical Record or Specific Information

Emergency Contact:

Name: _____ Relation: _____ Phone Number: _____

I understand and acknowledge the following:

1. I understand that Women’s Cancer Care Associates will not release any information to any person not listed above, unless the disclosure is for treatment, payment, and health care operations activities.
2. I have received the Women’s Cancer Care Associates Notice of Privacy Practices.
3. My protected health information may be subject to re-disclosure by one or more of the persons named above and as such may no longer be protected by state or federal law.
4. This authorization does not expire, unless effectively revoked in writing.

Patient Signature: _____ **Date:** _____

Patient Representative or Guardian:

Print Name: _____ **Relationship to patient:** _____

What is your authorization to act on the patient’s behalf?: _____

Signature: _____ **Date:** _____

Family History

List disease with age at time of diagnosis.
Please specify maternal or paternal where applicable.
Please check box if family member is deceased.

Family Member	Disease	Age	Deceased	Family Member	Disease	Age	Deceased
Mother				Father			
Grandmother				Grandfather			
Sister				Brother			
Aunt				Uncle			
Daughter				Son			

Social History

Living: With family Alone Care Facility

Occupation: _____

Do you drink alcoholic beverages?: No Yes If yes, how many? Daily___ Weekly ___ Monthly ___

Do you smoke tobacco? No Yes, if yes, how many packs

Have you used illegal drugs?: No Yes If yes, when? _____

Do you use Marijuana?: No Yes If yes, do you have a Medical Marijuana card? No Yes Have

you ever had a blood transfusion? No Yes If yes, please list reason: _____

**Most recent transfusion _____

Obstetric and Gynecologic History

Number of pregnancies_____ Number of live births_____

Number of vaginal deliveries_____ Number of cesarean sections _____

Miscarriage_____ Abortion_____

Are you currently pregnant No Yes Do you use contraception No Yes

Have you used estrogen or hormone replacement No Yes If yes, for how long?_____

Age of first menstrual period_____

Age at menopause if reached_____

Sexually transmitted infections_____

Other gynecologic problems (example: fibroids, endometriosis)_____