



**HAROLD A. NORD M.D.**  
**OBSTETRICS AND GYNECOLOGY S.C.**

---

1302 Franklin Avenue, Suite 3000  
Normal, IL 61761

Phone: 309-454-3456  
Fax: 309-454-6977  
[www.hnordobgyn.com](http://www.hnordobgyn.com)

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. Also included is a patient Registration Form. Please complete the form and bring it 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,

The Office of Dr. Harold Nord



# HAROLD A. NORD M.D. OBSTETRICS AND GYNECOLOGY S.C.

---

1302 Franklin Avenue, Suite 3000  
Normal, IL 61761

Phone: 309-454-3456  
Fax: 309-454-6977  
www.hnordobgyn.com

## 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.

Revised 1.1.11/ssb



# HAROLD A NORD MD OBSTETRICS/GYNECOLOGY SC

1302 Franklin Avenue, Suite 3000, Normal, IL 61761 Phone: 309-454-3456 Fax 309-454-6977

## HEALTH HISTORY SUMMARY

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

<b>SOCIAL HX</b>	
<b>Smoking</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes PPD History
<b>Alcohol</b>	<input type="checkbox"/> No <input type="checkbox"/> Social Drinks per week/month
<b>Street Drugs</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes Notes:
<b>Exercise</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Sometimes
<b>Nutrition</b>	<input type="checkbox"/> Excel <input type="checkbox"/> Good <input type="checkbox"/> Poor Notes:
<b>Safety</b>	Seatbelt <input type="checkbox"/> Yes <input type="checkbox"/> History of Abuse

<b>ALLERGIES</b>	<b>NKA</b>
Latex <input type="checkbox"/> IV Dye <input type="checkbox"/> PCN <input type="checkbox"/> Sulfa <input type="checkbox"/>	
Other:	

<b>CURRENT MEDICATIONS /SUPPLEMENTS</b>	

<b>HOSPITAL/SURGICAL HISTORY</b>	<b>NONE</b>

<b>GYNECOLOGIC HISTORY</b> Last Menstrual Period:				<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> BSO	<input type="checkbox"/> Menopause
First Menses:	Cycle 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 Abnormal Pap: _____					Sexual Parter History Now/Total /	
Method of Contraception:						

<b>PREGNANCY HISTORY</b>							<b>NONE</b>
#	Year	Sex	Weight	Weeks	Type of delivery	Pregnancy or Delivery Complications	
1							
2							
3							
4							
5							
6							
7							
8							

<b>PERSONAL/FAMILY HISTORY</b>					
	Patient	Family		Patient	
Birth Defects/Genetic Disorders				Pulmonary problems	
Multiple Births				Bowel/Abdominal problems	
Diabetes				Kidney- urinary problems	
↑ Cholesterol				Musculo-skeletal 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 disorders				Rheumatic fever	
Mental disorders				Infertility	
Endometriosis/Other History				Other History	

<b>CANCER Hx</b>	<b>NONE</b>
Female (breast, ovarian, uterine, cervical)	
Other (colon, skin)	

# Harold A. Nord OB GYN. S.C.

1302 Franklin Ave Suite 3000

Normal, IL 61761

(309) 454-3456

PATIENT INFORMATION									
NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	LANGUAGE	SEX	
LOCAL ADDRESS		CITY,STATE,ZIP		REFERRING PHYSICIAN		SECONDARY BILLING ADDRESS (IF APPLICABLE)			
HOME PHONE	DAY PHONE	EMAIL ADDRESS		PRIMARY CARE PROVIDER		CITY, STATE, ZIP			
MARITAL STATUS	STUDENT STATUS:	F/T	P/T	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE
PRIMARY EMPLOYER					SECONDARY EMPLOYER (IF APPLICABLE)				
ADDRESS					ADDRESS				
CITY, STATE, ZIP					CITY, STATE, ZIP				
WORK PHONE					WORK PHONE				
RESPONSIBLE PARTY INFORMATION (if different than above)									
NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	LANGUAGE	SEX	
LOCAL ADDRESS		CITY,STATE,ZIP		REFERRING PHYSICIAN		SECONDARY BILLING ADDRESS (IF APPLICABLE)			
HOME PHONE	DAY PHONE	EMAIL ADDRESS		PRIMARY CARE PROVIDER		CITY, STATE, ZIP			
MARITAL STATUS	STUDENT STATUS:	F/T	P/T	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE
RELATIONSHIP TO PATIENT									
PRIMARY INSURANCE									
NAME OF INSURANCE COMPANY						POLICY #			
NAME OF INSURED				BIRTHDATE		GROUP #			
ADDRESS OF INSURANCE COMPANY						COPAY AMT \$			
CITY, STATE, ZIP						DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT						EFFECTIVE DATE		EXPIRATION DATE	
SECONDARY INSURANCE (if applicable)									
NAME OF INSURANCE COMPANY						POLICY #			
NAME OF INSURED				BIRTHDATE		GROUP #			
ADDRESS OF INSURANCE COMPANY						COPAY AMT \$			
CITY, STATE, ZIP						DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT						EFFECTIVE DATE		EXPIRATION DATE	

I, the undersigned certify that I (or my dependent) have insurance coverage. I assign directly to Dr. 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 the payment of benefits. I authorize the use of this signature on all insurance submissions and any collection processes.

\_\_\_\_\_  
SIGNATURE OF PATIENT/GUARDIAN

\_\_\_\_\_  
DATE