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Clinton Women's Healthcare, PC

Obstetrics and Gynecology
clintonwomenshealthcare.com

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Clarkston, Michigan 48346
Phone: (248) 922-0856 Fax: (248) 922-9368

Today's Date: _____ Patient name: _____

Welcome to ClintonWomen's Healthcare. As Obstetricians and Gynecologists, we are concerned with the health and welfare of women throughout their lives.

We are committed to offering patients quality medical care in a sensitive, respectful, and compassionate setting. You deserve to be treated by a physician knowledgeable in the latest developments in obstetric and gynecologic medicine. We encourage you to take an active part in your medical treatment plan, so your questions and comments are always welcome. Below are some of our policies for your review and acknowledgement.

Office Operations: Patient appointments are made Monday through Friday from 8am until 4pm. The office is closed from 12pm-1pm daily for lunch. Our office provides appointment reminder calls for each office location. Appointments require a 24 hour notice of cancellation. A *"No show fee" of $25* will be applied to your account if you fail to call or cancel on the second offense. You are considered "late" for your appointment if you should arrive 15 minutes after the scheduled time and may be asked to reschedule for a future date.

Consent to Treat: I give my consent for the providers and staff at Clinton Women's Healthcare to review and treat conditions presented to them. I consent to certain diagnostic tests and understand that specimens of blood, urine, and other bodily fluids, tissues, or products may be obtained. I understand that it may become necessary that I be tested for antibodies to Human Immunodeficiency Virus (HIV, the virus that causes AIDS) I will be counseled by my physician and I will be given the choice of counseling in writing for such testing. I have been informed that my written consent to testing for HIV antibody or other communicable disease is not required by law in a situation where a health care provider sustains an exposure to my blood or bodily fluids.

Privacy Policy: We ensure that your privacy is a priority and ask that you download and review the *HIPAA Notice of Policy practices* and agreement from our website or ask the receptionist for a copy. The uses and disclosures by us, of your Protected Health Information (PHI) are necessary and will be used in connection with your treatment, or obtaining payment for treatment and services that this office provides to you, and so that this office can conduct its health care operations.

You have the right to review our notice of privacy practices prior to you signing this consent. Please be advised that the notice of privacy practices may be revised as instructed by the Department of Health and Human Services from time to time. Any such revisions will be made available to you at the time of your return visit. You should review carefully the notice of privacy practices because it contains a list of rights that are available to you with respect to this offices use and disclosure of your protected health information. These rights include your right to request restrictions on our use and disclosure of your protected health information.

Communication: It's important to know how to communicate privately regarding your healthcare needs and follow up. Please review the questions below to assist our staff in providing the best way to communicate with you:

Patient Name:	**DOB:**
Best way to reach you 8am-4pm?	☐ Primary Phone ☐ Alternate Phone ☐ Email
Messages:	☐ Ok to leave message on answering machine regarding my medical condition(s) or account matters. ☐ NOT OK to leave message of answering machine
Family:	☐ OK to speak with a family member regarding my medical condition(s) or account matters. Name: _____ Relation: _____ ☐ NOT OK to speak with any family member
Best way to confirm appointments:	☐ Primary Phone ☐ Alternate Phone
Waiting room:	How would you like the staff to address you when calling you back to the exam room? ☐ First Name ☐ Last Name ☐ First and Last Name
Office reminders:	☐ OK for our staff or automated attendant to contact me for Appointments and office reminders ☐ NOT OK to contact me for appointment or office reminders
Special Instructions:	

Patient Secure Health Record Access: Clinton Women's Healthcare is committed to providing you with the latest updates regarding your healthcare needs. By providing your email address at registration, you will be invited to create your own ***CWH Health Record Account*** and communicate electronically by viewing lab results, requesting prescription refills, asking our staff medical questions, requesting appointments and requesting medical record forms and transfers.

Prescription Policy: With recent efforts to keep the cost of medications down, the Physicians primarily prescribe generic brand drugs. *Prescription refill requests* can be done by calling the office prescription line or by signing in on your *CWH Health Record Account* to send requests. Refill requests require 48- 72 hours for processing.

Pharmacy Information:

Local Pharmacy	Address/Location	Phone:	Fax:
Mail In Pharmacy	**Address/Location**	**Phone:**	**Fax:**

Race (Please circle)

American Indian / Alaska Native	Caucasian (White)	Other Pacific Islander
Asian	Native Hawaiian	Refused to Report
African American	More than one race	Undefined

Ethnicity (Please circle)

Hispanic or Latino	Refused to Report
Non Hispanic or Latino	Undefined

Patient Name: _____ DOB: _____

Financial Policy:
Many of the services provided in our Specialty Office are covered and paid by your insurance company. It is always good to keep up with the open enrollment changes with your insurance policy, and take a moment to verify your financial responsibility with your health care visits. All carriers offer online information and access to your policy information to make it easier for you.

Unfortunately, not all services are a covered benefit under your insurance policy, and in most cases members and dependants are required to satisfy a single/family deductible, co-insurance, or set copay. In the event that you fall under one of those plans, **copay payments are to be collected at the time services are rendered**. We accept cash, personal or company checks, in addition to Visa, Mastercard and Discover credit cards.

All eligible visits that qualify will be billed directly to your insurance carrier for processing and verification of payments. If you have a policy that is in "*pending status*", we require the patient to pay the insurance allowable amount at the time of service; once the claim is cleared for processing and payment is received, the patient will receive full refund based on final determination of your out of pocket responsibility.

Statements about *Your Health Account* are sent monthly. The required payment agreement is to submit payment upon receipt of the account statement. You can access our website for *online bill pay options*. Payment Plan options are available through the Billing Office and require monthly payment activity to keep active. If the account balance should reach outstanding over 60 days your account will go into "*collection*" status.

We are here to help! If you have any questions or concerns regarding your insurance coverage, please do not hesitate to contact our Billing Department for assistance.

Forms: Disability, FMLA and various medical forms are processed through our clinical staff. Due to the nature, significant volume and the accurate information needed, our staff needs 7 to 10 business days to process and we require a $10 processing fee payable at the time of pick up.

I hereby acknowledge review of the Privacy Statement offered and understand a copy can be provided to me. I acknowledge I am at least 18 years of age, have read, understand and agree to abide by the policies described above. Further, all information I have provided is accurate to the best of my knowledge. If I wish to revoke this authorization, notice must be provided to the office staff in writing.

Patient Signature of acknowledgement and agreement: (original to use for comparison)

X _____ Date: _____

I authorize Clinton Women's Healthcare to release any medical information requested by my health insurance company to assist with processing medical claims submitted.

I hereby authorize payment directly to Clinton Women's Healthcare from the active insurance policy I provide on file, for any medical or surgical services performed in the office setting or at Troy Beaumont Hospital. I shall be legally responsible for any out of pocket costs, such as co-pays, deductibles and services that may not be a covered benefit under my active policy.

My signature below acknowledges my authorization to the above agreements Provided by Clinton Women's Healthcare, PC.

Patient / Guardian Signature:

X _____ Date: _____

FOR MEDICARE PATIENTS ONLY

Patients with Medicare Coverage are eligible for an annual exam, including pap smear, every two (2) years. If you request to have an annual exam outside the benefit determination from Medicare, you will be responsible for payment of those services.

I request payment of authorized Medicare benefits to either myself or Clinton Women's Healthcare on my behalf for services rendered through the physicians of Clinton Women's Healthcare. I authorize Clinton Women's Healthcare, the holder of my medical and other information, to release to Medicare and its agents if needed to determine if benefits are covered for any related services.

Medicare Patient Signature of acknowledgement and release of information:

X _____ Date: _____

Patient Signaure

☐ I present with no insurance coverage and ask that no medical information be released to any insurance company who requests with out my authorization.

Today's Date: _____ Patient name: _____

Advanced Directives (Durable Power of Attorney)

During complete physical examinations we like to address health issues are well as preventative issues. Michigan law requires physicians to advise patients about their rights to create an advance directive, or otherwise referred to as Durable Power of Attorney. This document provides you with a means to appoint a person to make health care decisions in the event you become incapacitated.

Our office has advance directive forms available for your review. Your insurance Carrier is encouraging physician practices to inform you of this important document. You can visit our website at www.clintonwomenshealthcare.com to download a copy or call and request a form to be mailed or emailed to you. Upon completing the form, please provide our office with a copy so we may be aware of your wishes.

If you have any questions or concerns, please do not hesitate to contact any of our office staff.

I acknowledge that I have been introduced to the advance directive form that is available to me and that it is recommended to have one on file with my primary physician.

X _____ Date: _____
Patient Signature

☐ I currently have an advance directive form on file with my Primary Care Physician.
Physician Name: _____ Phone: _____

☐ I currently do not have an advance directive form on file with any physician.

How are we doing?
We welcome your feedback with all encounters at our offices or at Troy Beaumont Hospital. Please consider filling out a survey after your visits so we can be informed of your experience and share tips on how to serve you better.

We welcome new patients at Clinton Women's Healthcare! If you are pleased with your experience and the care you receive here, please share with your family and friends.

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For Office Use Only
Diag:
LMP:
Lab:

REGISTRATION DATA & INSURANCE INFORMATION Today's Date: _____

Patient Name (Please print as it appears on insurance card)

Last | First | MI | DOB | Sex | Social Security #

Address | City | State | Zip

Marital Status

☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Seperated

Primary Phone # | **Alternate** phone #

PATIENT EMPLOYER | Employer Phone #

Employer address | City | ST | ZIP | Occupation

Are you over the age of 18yrs? ☐ Yes ☐ No

SPOUSE *OR* PARENT/GUARDIAN (if minor)

Last | First | MI | Birth Date | Sex | Social Security #

Address (if different from patient) | Employer | Primary Phone #

EMERGENCY CONTACT PERSON: ☐ Spouse ☐ Parent/Guardian

☐ Other Name: _____ Relation _____ Phone# _____

PERSON FINANCIALLY RESPONSIBLE: ☐ Self ☐ Spouse ☐ Parent/Guardian

☐ Other Name: _____ Relation _____ Phone# _____

EMAIL address (used for patient portal acct): _____

INSURANCE INFORMATION

Primary Insurance Name

Patient relationship to Subscriber (check one)
☐ Self ☐ Spouse ☐ Dependant

Subscriber Last, First Name | Subscriber Social Security # | DOB

Secondary Insurance Name

Patient relationship to Subscriber (check one)
☐ Self ☐ Spouse ☐ Dependant

Subscriber Last, First Name | Subscriber Social Security # | DOB

Patient Questionnaire

Name _____ Date _____

Referred By: _____ Age _____

Birthdate _____

What is the reason for today's visit? _____

_____

_____

Menstrual History

Age of first period_____ Date _____

How many days between the start of one period to the start of the next?_____

Number of days of flow_____ Are periods regular? ❑ Yes ❑ No

Amount of flow? ❑ Light ❑ Medium ❑ Heavy Are periods painful/crampy? ❑ Yes ❑ No

Birth Control Method

❑ Birth Control Pills What brand?_____

❑ Tubal Ligation ❑ Condoms ❑ Intrauterine Device ❑ Diaphragm

❑ Foam ❑ Rhythm ❑ Vasectomy ❑ Abstinence None

Gynecology History

Do you have any history of the following problems? *(Now or in the past) Check those which apply.*

❑ Vaginal Infections
❑ Chlamydia
❑ Gonorrhea
❑ Syphillis
❑ Herpes
❑ HIV/AIDS
❑ Pelvic Inflammatory Disease
❑ Verneral Warts/Condyloma
❑ Endometriosis
❑ Ovarian Cysts
❑ Uterine Fibroids
❑ Premenstrual Syndrome
❑ Menopausal Symptoms
❑ Fibrocystic Breast Change
❑ Breast Discharge
❑ Breast Cancer
❑ Sexual Problems

Obstetrical History

List all Pregnancies including live births, stillbirths, Miscarriages, abortions and tubal pregnancies...

Date	Hospital	Length/Pregnancy	Duration/Labor	Type/Delivery	Problems

Medical History

Please check if you have had any of the following conditions.

❑ Mumps
❑ Chicken Pox
❑ German Measles
❑ Rheumatic Fever
❑ Tuberculosis
❑ Diabetes
❑ Thyroid Disease
❑ Arthritis
❑ Anemia
❑ Blood Clots
❑ Systemic Lupus Erythematosus (SLE)
❑ High Blood Pressure
❑ Heart Disease
❑ Mitral Valve Prolapse
❑ High Cholesterol
❑ Lung Problems
❑ Kidney Stones
❑ Bladder Infections
❑ Ulcers
❑ Bloody/Tarry Stools
❑ Liver Disease
❑ Seizures
❑ Stroke
❑ Headaches
❑ Cancer
❑ Blood Transfusion
❑ Glaucoma
❑ Hearing Problems
❑ Skin Problems
❑ Major Accident
❑ Depression

Patient Questionnaire
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Surgery/Hospitalizations

Year	Operation/Medical Problem	Year	Operation/Medical Problem

Medication *(including Vitamins)*

Medication	Dosage

Allergies *(List all allergies to medication)*

Social History

Occupation_____

Marital Status ❑ Single ❑ Married ❑ Widow ❑ Divorced

Sexual Preference ❑ Heterosexual ❑ Homosexual ❑ Bisexual

Do you exercise? ❑ Yes ❑ No Type of exercise_____ Times per week_____

Do you smoke? ❑ Yes ❑ No Number of cigarettes per day?_____

Do you drink alcohol? ❑ Yes ❑ No Number of drinks per week?_____

Do you use drugs? ❑ Yes ❑ No Type of drugs used _____ Frequency_____

Family History

Please check if a relative has the following conditions. Indicate their relationship to you.

❑ Heart Disease	_____	❑ Ovarian Cancer	_____
❑ High Blood Pressure	_____	❑ Uterine Cancer	_____
❑ High Cholesterol	_____	❑ Colon Cancer	_____
❑ Diabetes	_____	❑ Breast Cancer	_____
❑ Birth Defects	_____	❑ Osteoporosis	_____
❑ Other	_____	❑ Other	_____

Screening Tests

Date of PAP Test	_____	❑ Normal ❑ Abnormal	*(If abnormal PAP indicate date and treatment below.)*		
Date of last Mammogram	_____	❑ Normal ❑ Abnormal	Date	Treatment	
Date of last Cholesterol	_____	❑ Normal ❑ Abnormal	_____	_____	
Date of last Sigmoidoscopy	_____	❑ Normal ❑ Abnormal	_____	_____	
Date of last Stress Test	_____	❑ Normal ❑ Abnormal	_____	_____	

Other Information

Please list any other pertinent medical information or questions you would like to address.

_____

_____

_____

_____

_____

_____