Women First OB/GYN Demographics

326 N. Main Street, Royal Oak, Michigan 48067
390 Park St. Suite 109, Birmingham, Michigan 48009

Today's Date: ________________________Birth Date:__________________

Last Name: ______________________ First Name: _____________________MI: _____

Email Address:___________________________________
How would you like us to contact you for abnormal test results?
(please circle one) Email Phone

How Should our Staff Address You: _______________________________________
Marital Status: (please circle one) Single Married Widowed Divorced
SS # __________________Gender:__________Race:__________________________
Preferred Language:______________________Ethnicity:_______________________
Address: ____
City: __________________________State: ________________Zip: ______________
Home Phone: ___________________Cell Phone: ___________________________
Employer:____
Occupation: __________________________Work Phone: _______________________

Spouse's Name: ____
Spouse's S.S#____________________ Spouse's Birth Date: _______________
Spouse's Employer: _________________________ Phone ____________________

Insurance Company Name: ____
Policy Holder's Name: __________________Relationship/Birthdate_________

Emergency Contact: ____
Relationship to You: ____
Emergency Contact Phone: ____

Referred By: ____

Primary Physician Name: ____
Address: ______________________________________Phone: __________________

Pharmacy Name: ____
Address/Street: ____________________________________Zip Code:___________
Phone: ____

By signing this form, I agree to pay my portion of the billing at the time services are rendered

Signature: ____

Identification Verified (Office Use Only) ______

Women First OB/GYN Center

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Women First Ob/GYN Center may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Women First Ob/GYN Center's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Women First Ob/GYN Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be viewed at the office of Women First Ob/GYN Center.

With my consent, Women First Ob/GYN Center may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, and insurance inquiries.

With my consent, Women First Ob/GYN Center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Women First Ob/GYN Center may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Women First Ob/GYN Center restrict how it uses or discloses my PHI to carry out TPO. Women First Ob/GYN Center will not honor such requested restrictions as we believe that the systems that we have in place to monitor and notify patients about follow up visits, tracking mammograms, tracking pap smears, and patient notification policies is inherent to a quality safe practice policy. If you believe strongly in your requested restrictions we will assist you in finding alternative health care options.

By signing this form, I am consenting to Women First Ob/GYN Center's use and disclosure of my PHI to care out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Women First Ob/GYN Center will decline treatment to me.

I understand I am to pay for services at the time they are rendered. However, I have requested Women First to bill my insurance company on my behalf for these services. I understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt payment of my bill.

______________________________________ ____________________

Print Patient's Name Date of Birth

______________________________________ ____________________

Signature of Patient or Legal Guardian Date

Women First OB/GYN Center

PATIENT and MINOR CONSENT FORM FOR

TEST RESULTS AND HEALTH INFORMATION

Under the requirements for HIPAA we are not allowed to give information to anyone without the patient's consent. Please state in the space below any family members you wish to have medical information, any diagnostic test results and/or financial information released to, **not including physicians**. If you DO NOT wish to release information to anyone, please write "decline" then sign and date form.

I ________________________________give my consent to Women First OB/GYN Center to release both written and verbal confidential health information to:

Name	Relationship	Phone Number

______________________________ ____________________

Signature of patient Date

____

Date of Birth

Welcome to Women First OB/Gyn Center! Thank you for choosing us for your obstetric and/or gynecological needs. As our patient, you are a partner in the care you receive at our practice.

PROVIDER – PATIENT AGREEMENT

We want your visit with us to be pleasant! Please take a moment to review our list of doctors, office hours, and what to bring with you to your appointment.

WHAT YOU NEED TO KNOW:

- Bring your insurance card(s) and valid photo identification. We cannot see you without your insurance card(s)/identification card.
- Appointments are required; we are not a walk-in clinic.
- Please arrive 15 minutes prior to your scheduled appointment.
- If you are late for your appointment, you may be asked to reschedule if we are unable to accommodate you that day.
- If you cannot keep an appointment, please give us 24-hours' notice or sooner, allowing for the appointment time to be utilized for another patient in need.
- Patients who miss office or test appointments, or arrive late without prior notice, will be considered "no shows" in our system. Three or more "no shows" could result in dismissal from our practice. (*We reserve the right to charge $50.00 for a "no show" appointment.*)
- For a prescription refill, please call your pharmacy. Plan ahead to be sure you have an adequate supply before needing a refill.
- Call the office with questions or for medication advice; a registered nurse will answer or return your call with 48 hours. (Always call 911 for emergencies.)

****NOTE:** *It is your responsibility to know your insurance benefits.***

DISMISSAL POLICY:

We value you as a patient and want to partner with you in your health care. Unfortunately, some situations may make it necessary for us to dismiss patients from our practice. These include but are not limited to:

- Noncompliance with office visits, medical regimens for tests/procedures, or referrals to specialists.
- Abusive, threatening behavior to any staff of Women First OB/Gyn Center or other patients, in person or by phone.
- Altering prescriptions.
- Falsifying any document from Women First OB/Gyn Center.
- Arriving for appointments or medical advice intoxicated or under the influence of recreational drugs.

I understand the guidelines for patient partnership with Women First OB/Gyn Center and agree to Follow the recommendations of my provider(s) to ensure healthy outcomes in my health care.

____ ________________
Patient Name (PRINT) Date of Birth

____ ________________
Patient Name (SIGNATURE) Date