PATIENT INFORMATION

NAME ____
FIRST MIDDLE LAST MAIDEN

S.S.# ______________________________ BIRTHDATE ______________________

ADDRESS ____
STREET CITY STATE ZIP CODE

HOME PHONE ______________ BUSINESS PHONE ______________ CELL PHONE ______________

E-MAIL ______________________________ EMERGENCY PHONE ______________________

WHERE WOULD YOU PREFER US TO CONTACT YOU ______________ EMERGENCY CONTACT NAME ______________

WHO REFERRED YOU TO THIS OFFICE? ____

DO YOU HAVE ALLERGIES TO MEDICATIONS? ____

RACE ______________ MARITAL STATUS ______________ ETHNICITY ______________

PCP ____

INSURANCE INFORMATION

NAME OF INSURANCE ____

NAME OF SUBSCRIBER ______________________________ BIRTHDATE ______________

S.S. # OF SUBSCRIBER ______________________________ EMPLOYER ______________________

RELATIONSHIP TO SUBSCRIBER ____

DO YOU HAVE ANY SECONDARY COVERAGE? ____

SECONDARY INSURANCE

NAME OF INSURANCE ____

NAME OF SUBSCRIBER ______________________________ BIRTHDATE ______________

S.S. # OF SUBSCRIBER ______________________________ EMPLOYER ______________________

RELATIONSHIP TO SUBSCRIBER ____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. In order to control the cost of billings, we request that our charges for office visits be paid at the conclusion of each visit.

I hereby assign all medical and/or surgical benefits to which I am entitled including Medicare, private insurance and other health plans to: Michigan Women's Health Institute. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information to secure the payment, including copies of portions of the patient's records.

SIGNED ______________________________ DATE ______________

GYN QUESTIONAIRE

PATIENT NAME______________________

REASON FOR VISIT____

LAST MENSTRUAL PERIOD__________________

HOW MANY TIMES HAVE YOU BEEN PREGNANT _________

HOW MANY LIVE BIRTHS_____________________

ARE YOU PLANNING TO BECOME PREGNANT___________

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING
PRESCRIPTIONS____
NON-PRESCRIPTION____
VITAMINS____
HERBAL____

LERGIES____

SURGICAL HISTORY____

FORM OF CONTRACEPTION______________ ANY SEXUAL ISSUES______________

LAST PAP SMEAR_________________ ANY ABNORMAL PAP SMEARS______________

LAST MAMMOGRAM__________________ ANY ABNORMAL MAMMOGRAMS__________

FAMILY HISTORY OF BREAST OR GYNECOLOGICAL CANCERS YES____ NO____
IF YES, WHAT TYPE OF CANCER__________________________
RELATIONSHIP______________________________________

FAMILY HISTORY OF DIABETES YES_____ NO_____
HIGH BLOOD PRESSURE YES_____ NO____ HIGH CHOLESTEROL YES____ NO____
HEART DISEASE YES_____ NO____
ANY OTHER DISEASE YES_____ NO____ IF YES, WHAT_______________

SMOKER YES____ NO____ ALCOHOL YES____NO____ DRUGS YES____ NO____
SEXUAL ABUSE YES____NO_____ IF YES, HOW LONG ________________

DO YOU HAVE HEAVY PERIODS YES_____ NO_____
CYCLE LENGTH_____________ DURATION_______________

DO YOU HAVE HISTORY OF PELVIC PAIN YES_____ NO____

DO YOU HAVE HISTORY OF ENDOMETRIOSIS YES____ NO____

DO YOU HAVE PAINFUL PERIODS EFFECTING YOUR LIFE YES____ NO____

ARE YOU HAVING URINARY PROBLEMS (PAIN, FREQUENCY, LEAKING, URGENCY) YES____ NO____

MEDICAL INFORMATION DISCLOSURE AUTHORIZATION

I, ______________________________, hereby authorize and request my physicians, psychologist, hospitals, laboratories and all other health care providers to disclose all information concerning my health to my ________________, _______________________, including,

son/daughter/husband name

but not limited to, health information considered to be protected under the Health Insurance Portability and Accountability Act of 1996, PL 104-191, as from time to time amended ("HIPAA"). _________________ shall be considered my "personal representative" for all purposed of the privacy rule issued by the U.S. Department of Health and Human Services and as required by HIPAA.

I hereby grant full power to ________________ to access my medical records and information to the same extent that I am entitled, including the right to disclose the contents to others, and to execute releases in my behalf.

This Medical Information Disclosure Authorization shall be fully binding upon me, my heirs and my personal representatives.

Photocopies of this executed document shall have the same legal force and effect as the original for all purposes.

IN WITNESS WHEREOF, I have executed the MEDICAL INFORMATION DISCLOSURE AUTHORIZATION this _____ day of _________. 200 .

____

Patient

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF

PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of the **Michigan Healthcare Professionals, P.C.** Patient Notice of Privacy Practices effective September 23, 2013.

Date: ________ Patient Signature: ____
(or Guardian, if applicable)

MICHIGAN WOMENS HEALTH

Abraham Babaoff, M.D., Hamid Banooni, M.D., Neil Brickman, M.D., Deborah Charfoos, M.D., Andrea Eisenberg, M.D., Joanne Sandler Goldberg, M.D., Sakina Hakim, M.D., Renee Horowitz, M.D., Harold Leach, M.D., Esther Zekman, D.O. Stephanie Breining, N.P.

28555 Orchard Lake Road Suite 120
Farmington Hills, Michigan 48334
248-489-1070

Dear Patient

Due to recent changes we are unable to control, we feel it necessary to inform you of our billing procedures for your visit today.

If you are here today for you annual pap smear, also known as a Well Woman Exam, we must bill your visit to your Insurance Company with the code V723. This code clearly indicates that you are here today for Preventative Health Care and have not scheduled this appointment because of a new or recurrent medical problem.

If your primary reason for your visit today is to have your contraceptive refilled or your hormone replacement therapy refilled, this is also considered part of the Well Woman Exam or Preventative Health Care and will not be billed with a different diagnosis.

While we realize that you may have other concerns to discuss with your doctor at the time of your Well Woman Exam such as irregular menses, infection, premenstrual syndrome, etc., they do not qualify for a different diagnosis.

If your visit has been scheduled for a reason other than your Well Woman Exam, and the focus of your visit is something other than Preventative Health Care, we will bill your visit to your Insurance Company with the appropriate diagnosis as documented by your Physician. Our billing department will bill only what the physician has requested and cannot change a diagnosis code per patient request.

While our physicians recommend an annual pap smear and Well Woman Exam, we cannot guarantee that your insurance will cover the cost of this visit. It is your responsibility to know your individual coverage and pay for any copays, deductibles, or other services not covered by your insurance.

If you have any questions, please feel free to discuss them with your physician or our billing department.

I have read the above and confirm that I understand the billing policies of this office in regards to my Well Woman Exam

_______________________________ ______________

Signature Date