PATIENT INFORMATION

NAME _____
FIRST MIDDLE LAST MAIDEN

BIRTHDATE _____ LAST 4 OF S.S. # _____

ADDRESS _____

HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE _____

E-MAIL _____ EMERGENCY PHONE _____

WHERE WOULD YOU PREFER US TO CONTACT YOU? _____

EMERGENCY CONTACT NAME AND PHONE # _____
NAME PHONE #

WHO REFERRED YOU TO THIS OFFICE? _____

DO YOU HAVE ALLERGIES TO MEDICATIONS? _____

RACE _____ MARITAL STATUS _____ ETHNICITY _____

PRIMARY CARE PHYSICIAN _____

PHARMACY NAME _____ PHARMACY PHONE _____

PHARMACY ADDRESS _____

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 _____

RELATIONSTHIP TO SUBSRIBER _____

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 _____

PATIENT # _____ (OFFICE USE ONLY)

H. Banooni MD, N. Brickman MD, D. Charfoos MD, A. Eisenberg MD, S. Hakim MD,

R. Horowitz MD, H. Leach MD, and E. Zekman DO, S. Breining NP

Dear Patient:

For your convenience and safety, we are introducing a computerized prescription program that will improve both the accuracy and convenience of prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases, it will also accommodate the transmissions of your prescription to mail order pharmacies.

To implement this new program, we need to collect some information from you on your pharmacies of choice. We will define one pharmacy as your main pharmacy; however, you may also provide the information or additional pharmacies to be used as an alternative. In addition you have a mail order benefit program, please provide that information by selecting the appropriate box below.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone, fax) as any information provided will be helpful.

PATIENT NAME:_____ DATE OF BIRTH:_____

MAIN PHARMACY:
Name (i.e. CVS, Rite-Aid, etc):_____

Street Name & City:_____

Phone:_____ Fax:_____

ADDITIONAL PHARMACIES YOU WOULD LIKE KEPT ON FILE:
Name (i.e. CVS, Rite-Aid, etc):_____

Street Name & City:_____

Phone:_____ Fax:_____

Name (i.e. CVS, Rite-Aid, etc):_____

Street Name & City:_____

Phone:_____ Fax:_____

MAIL ORDER:

- ☐ Medco
- ☐ CareMark/ Pharmacare
- ☐ Express Scripts, Inc.
- ☐ Other_____

PLEASE LIST ALL YOUR DRUG ALLERGIES:

_____

_____

_____

OBGYN QUESTIONNAIRE 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_____

ALLERGIES_____

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____

MICHIGAN WOMENS HEALTH

Hamid Banooni, M.D., Neil Brickman, M.D., Deborah Charfoos, M.D., Andrea Eisenberg, 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 your annual pap smear, also known as a Well Woman Exam, we must bill your visit to your Insurance Company as an annual exam. The appointment that you are here for today is for a Well Woman Preventative health care Gynecological exam and has not been scheduled for 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

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 _____ (son/daughter/husband), _____ (name), including, 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)