NORTHWOOD
OBSTETRICS & GYNECOLOGY

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First:	Middle:	Marital status:

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name (if applicable):	Birth date:	Age:

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Pharmacy:

Chose clinic because/referred to clinic by (Please choose one option): ○ Referring Doctor:_____

○ Reason for today's visit:_____

Email Address (this gives you access to your Patient Portal, we will never send you junk mail):

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insured's name (write 'self' if you are under your own plan):	Birth date:	Address (if different):	Home phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber (primary insurance):

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber (secondary insurance):

IN CASE OF EMERGENCY

Emergency Contact:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Northwood Obstetrics & Gynecology or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date

Medical Information Release

Authorized Contacts: By listing the persons below, I am authorizing Northwood Obstetrics & Gynecology to release information contained in my patient records – including demographic information, allergies, medications, immunizations, lab reports, problems and diagnosis, birth control and abortion, sexually transmitted diseases, and genetic diseases or test results. This may include information created before and after the date of this authorization. You may authorize multiple individuals, and they do not need to be the same individual listed as your emergency contact.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

COMMUNITY REGISTRY AUTHORIZATION:

Northwood Obstetrics and Gynecology participates in a ***community registry*** operated by Northern Physicians Organization (NPO). Your providers that participate in this registry may share your electronic health information. The registry is a tool that your providers can use to manager and coordinate your care allowing them immediate access to your healthcare data. This data can be used to conduct healthcare quality assessment and improvement activities along with population health assessments.

What may be disclosed to participating health care entities:

Northwood may disclose your health information, including demographic information, allergies, medications, immunizations, lab reports, problems and diagnosis, mental health conditions, birth control and abortion (family planning), alcohol or drug use problems, your care plan, health care providers, sexually transmitted diseases (STDs), HIV/AIDS, and genetic diseases or test results. This includes information created before and after the date of this authorization.

Who may receive the information?

1) I authorize my provider to disclose my health information to the community registry and its **participating physicians and physician groups** that have entered into a written agreement with NPO, before or after the date of this authorization; and
2) I authorize NPO to disclose my health information to (a) its participating physicians and physician groups that have entered into a written agreement with NPO before or after the date of this authorization; and (b) other health care service providers that have entered into a written agreement with NPO, where they have agreed to comply with HIPAA and Michigan Privacy Laws.

The purpose of this sharing of data:

I allow disclosure of my health care information for medical treatment, to coordinate care among my providers, and to improve my providers' health care operations.

Expiration: This consent will expire, (i) upon my death, (ii) when my Provider ceases its relationship with NPO, or (iii) NPO ceases operation of the community registry, whichever is sooner. Or I may revoke my permission at any time by giving written notice to my provider except to the extent the disclosures I agreed to have already been acted on.

Additional Rights: I understand that I have additional rights under HIPAA, including the right to request restrictions on certain uses and disclosures of my health information, the right to inspect and copy my health information, and the right to request uses and disclosures of my health information, the right to inspect and copy my health information, and the right to request amendments to my health information, and that these right are further explained in my Provider's Notice of Privacy Practices.

**The software system used by NPO meets the privacy and security standards of both the Health Insurance Portability and Accountability Act (HIPAA) and Michigan law.*

Please Check One:

□ I opt-in to the NPO Community Registry

□ I opt-out of the NPO Community Registry

X _____

Signature of Patient/Today's Date

X _____

Parent or Guardian Signature/Today's Date

NEW PATIENT
MEDICAL HISTORY FORM

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Full Name: _____ Date: _____

Birth Date: _____ Age: _____

ALLERGIES ❑ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	Other:

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PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies:	Number of Live Births:
Pregnancy Complications:	

Patient Name: _____ DOB: _____

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FAMILY MEDICAL HISTORY ❑ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

✔ CHECK ALL THAT APPLY	Alcohol/Drug Abuse	Asthma	Cancer (type:_____)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:_____	Other:_____	Other:_____
Mother																		
Father																		
Brother																		
Sister																		
Child																		
Maternal Grandmother																		
Maternal Grandfather																		
Paternal Grandmother																		
Paternal Grandfather																		
Other:_____																		

SOCIAL HISTORY

Occupation:	❑ Retired ❑ Unemployed ❑ LOA ❑ Disabled
Employer:	
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: ❑ Single ❑ Partner ❑ Married ❑ Divorced ❑ Widowed ❑ Other:_____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	❑ Beer ❑ Wine ❑ Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N	Have you ever used needles to inject drugs? Y N		
Have you ever taken someone else's drugs? Y N			

Patient Name: _____ DOB: _____

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OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Are you currently sexually active? Y N
Sexual partner(s) is/are/have been: ❑ Male ❑ Female	
Birth control method: ❑ None ❑ Condom ❑ Pill/Ring/Patch/Inj/IUD ❑ Other:_____	
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*
What kind of exercise?	***Duration:*** How long (min.): _____ How often: _____
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?
DIET	How would you rate your diet? ❑ Good ❑ Fair ❑ Poor
SAFETY	Do you feel safe at home? Y N Do you use seat belts consistently? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Primary Care Physician (PCP)		
Gastroenterologist (GI)		
Cardiology		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Patient Name: _____ DOB: _____

NORTHWOOD OB/GYN FINANCIAL POLICY

Thank you for choosing Northwood OB/GYN as your health care provider. The following information is provided to ensure you are aware of and understand our financial policies. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc.).

This policy is important! Please read the entire document and initial next to each paragraph to indicate you understand and agree with our policy. It is your responsibility to know, understand, and abide by our financial policy:

_____**Co-pays/Co-Insurance/Deductibles** -The patient is expected to present an insurance card at each visit. All co-payments, co-insurance, deductibles and past due balances are due at the time of your appointment. We accept cash, checks, or credit cards for your convenience. If a patient is a minor (17 years and younger) and is using a parent's insurance benefit, the parent or guardian must sign below. The parent or guardian is responsible for any payment due at the time of service. If you are unable to pay for necessary medical care, you may be eligible to participate in a payment plan. It is your responsibility to inform us of your financial need *prior* to your visit. Please ask to discuss arrangements with our billing department.

_____ **Annual Exams** – These visits are intended to be preventative in nature and typically include age appropriate history, exams and counseling. These visits are not intended to be problem-focused. While we are happy to manage additional problems that exist at the time of an annual exam if possible, it may be appropriate to change the type of visit such that a co-payment would be required. This decision cannot be made until your visit has been completed and may depend upon the nature of the problem and the amount of time required to adequately address it.

_____**Insurance Claims** – Any balance after processing of our claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in-network with your insurance company. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete and up-to-date insurance information may result in patient responsibility for the entire bill. It is your responsibility to know your insurance benefits as it may not cover all of the services provided to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered including, but not limited to those charges above the usual and customary allowance. If we are out-of-network, and your insurance pays you directly, you are responsible for payment in full and agree to forward the payment to us immediately.

_____**Self-pay Accounts** – Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. Northwood is happy to offer self-pay patients a 15% discount for payments made in full. Please note this discount will only apply to

payments made with cash or check and cannot be applied to co-pays, deductibles, credit card payments, medical devices, and some procedures.

_____Outstanding Balance Policy – A medical practice, like any business, depends on timely payments. It is our policy that all accounts remain current. In the event that a patient balance remains outstanding for more than 90 days and no resolution can be made, your account will be sent to a collection agency and you will be discharged from our Practice. We reserve the right to refuse general medical care if bills remain willingly unpaid. Please note – it is your responsibility to make sure your address and contact information is up to date with our office, this is the only way for us to ensure you are receiving statements. If your address is incorrect or your mail does not make it to you for any reason, you will still be subject to collections.

_____Laboratory Fees – If you have lab work drawn or other tests ordered, it will be billed to your insurance company. The lab or radiology balance is not usually included in the charges for your visit here, and you will receive a separate bill from the laboratory who analyzes the test (usually from Munson Medical Center Lab or Radiology Center). We do not submit claims for Munson Hospital – all claims for lab work and services there must be discussed with their billing department at 231-935-6160. It is your responsibility to know and understand what additional laboratory and radiology charges you may encounter, we cannot estimate these charges for you.

_____Additional Charges – There is a $20 charge for medical records fees (if not sent to another care provider). We charge a $20 processing fee for FMLA paperwork. You are responsible to pay a $30 fee for any no show appointment – please refer to our No Show Policy for more details on this fee.

_____Financial Policy for Obstetric Care: Please be advised of Northwood OB/GYN's policy concerning your pregnancy and insurance coverage. Unlike other types of services, prenatal care is billed globally and will be billed at the end of your pregnancy, after delivery. Prenatal care includes your routine office visits and delivery charges. During your pregnancy, physicians may order additional studies, such as ultrasounds or non-stress tests. These services will be billed to your insurance at the time of the service and are not included in the global prenatal care fee. Subsequently, these charges MUST be paid within 90 days of the date of service. Additionally, if you are seen for any problem or condition unrelated to your pregnancy, we are required to bill for the office visit. You may be responsible for co-pays and/or additional fees for these services, which will be determined by your contract with your insurance company. Please be aware of the cost of delivery. Some insurance companies apply part of the delivery charges as co-insurance and/or deductible. This balance is your responsibility and must be paid within 90 days of delivery.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

I have read and understand the above information and agree to comply with these financial policies.

Print Patient Name: _____Date of Birth: _____

Patient Signature:_____Today's Date: _____

Parent Signature (If patient is a minor):_____