



Today's Date:			PCP:		
PATIENT INFORMATION					
Patient's last name:		First:	Middle:	Marital status:	
Is this your legal name? <input type="radio"/> Yes <input type="radio"/> 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): <input type="radio"/> Referring Doctor: _____ <input type="radio"/> Reason for today's visit: _____					
Email Address (this gives you access to your Patient Portal, we will <u>never</u> 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

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): _____

Current Medications

Please list all medications you take, along with their dosage. Include any over-the-counter medications and vitamins as well. (Continue on backside if more space is needed)

Allergies

Please list any allergies you have and your reaction:

GYN-OB History

What was the date of your last menstrual period?

What was the year of your last pap smear, and what was the result?

When was your last pelvic exam (with or without a pap smear)?

Are you currently using a form of contraception? If yes, please list what you are using.

OB History

Please use the following rows to list out your previous pregnancies along with the year. Include if the pregnancy resulted in a miscarriage, ectopic, c-section, or vaginal delivery. (Continue on backside if more space is needed)

Past Surgical History

Please list any surgeries you've had and the year they took place:

Family History

Has anyone in your family ever been diagnosed with the following: heart disease; osteoporosis; colon cancer; blood clots; breast, uterine, or ovarian cancers; hypertension; diabetes; or addiction? Please specify their relation to you.

Social History

Do you feel safe at home?

Yes No

Marital status

Single Married Divorced Widowed

Where do you work/What do you do?

How much alcohol do you typically consume?

none < 3 drinks/week 3-6 drinks/week >6 drinks/week

Street/Recreational drug use - please select all that apply: (please note that we do a urine drug screen during the 1st trimester of pregnancy for all of our obstetrical patients per Munson Medical Center's policy)

no drug use marijuana (medical or recreational) cocaine IV drug use methamphetamines narcotics
 other

Smoking status: (never, current, former, # packs/day)
