

Current Medications: _____

Medication Allergies: _____ Reactions: _____

Medical History

Have You Had?	No	Yes	Date	Have You Had?	No	Yes	Date
Anorexia				Liver problem/disease (specify)			
Arthritis				Lung problem/disease (specify)			
Asthma				Mono			
Birth defects				Infertility			
Blood disorders/disease (specify)				History of Sexual or Physical Abuse			
Breast lump				Osteoporosis			
Cancer (specify)				Ovarian cysts/growths			
Chickenpox				Infection of uterus/tubes/ovaries			
Chlamydia				Psychiatric disorder (specify)			
Depression				Rheumatic fever			
Diabetes				Skin problems/disease (specify)			
Hard pain/cramps with periods				Stroke			
Ear problems/disease (specify)				Syphilis			
Epilepsy				Thyroid problems/disease (specify)			
Eye problem/disease (specify)				Tuberculosis			
Uterine growths/fibroids				Bladder infection			
Breast nipple discharge				Abnormal Pap smear			
Gastric ulcer				Other (specify)			
Genital warts							
Gonorrhea							
Hay fever/seasonal allergies							
Hepatitis (specify type)				Indicate whether you've had these tests and date of last one			
Do you ever miss a periods?				Pap smear			
Genital herpes				Mammogram			
Heart problem/disease (specify)				Colonoscopy			
High blood pressure				Bone density			
Kidney problem/disease (specify)				Thyroid			
Kidney infection				Cholesterol			

Surgical History

Date	List all previous hospitalizations, surgeries and procedures

Are you adopted? **No** **Yes** If yes, do you know your family history? **No** **Yes**

Family History

Has Any Blood Relative Ever Had?	No	Mat. Relative (specify)	Pat. Relative (specify)	Has Any Blood Relative Ever Had?	No	Mat. Relative (specify)	Pat. Relative (specify)
Arthritis				Goiter			
Asthma				Gout			
Birth Defect				Hay fever/allergies			
Blood disorder				Heart disease (specify)			
Breast cancer				Hepatitis (specify type)			
Cervical cancer				High blood pressure			
Ovarian cancer				Kidney disease (specify)			
Other cancer (specify)				Osteoporosis			
Birth defect				Stroke			
Diabetes				Thyroid disease			
Emphysema				Tuberculosis			
Endometriosis				Twins or Triplets			

Family Members

	Living	Health condition (poor/fair/good/excellent)	Deceased/Year/At what age
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Pregnancy History Have you ever been pregnant? Yes No

Please list all pregnancies

Delivery Date	Mo. Along	Vag or C-section	Complications	Living

Have you ever had a miscarriage or abortion? Yes No

Date	Wks. Along	Miscarriage	Abortion	Complications

Menstrual History

Age at first menstrual period _____

How often do you have periods? Every _____ days

How many days does period last? _____ days

Is your flow (circle one) Light Moderate Heavy

Bleeding/spotting between periods? No Yes

Pass clots with periods? No Yes

Current method of preventing pregnancy: (circle all that apply)

Abstinence (not sexually active) None (unprotected intercourse)
 Natural Family Planning Withdrawal Condoms Foam/Gel/Suppository
 Diaphragm Depo Provera IUD Oral Contraceptives
 Tubal Sterilization Partner Vasectomy Hysterectomy

Social History

Occupation _____

Substance Use

Caffeine never _____ times/day

Tobacco never _____ times/day

Alcohol never _____ times/week

Street drugs never _____ times/week

Education

Grade school _____ years

High school _____ years

College _____ years

Postgraduate _____ years

Patient Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Employer _____ Occupation _____
Driver's License # _____ Social Security # _____
Date of Birth _____ Marital Status M S W Sep D

Spouse Name _____ Date of Birth _____
Employer _____ Occupation _____ Work Phone _____
Spouse Social Security # _____

Primary Insurance _____ Effective _____
Policy Holder _____ Relationship to You _____
Policy Holder Date of Birth _____ Policy Holder Social Security # _____
Secondary Insurance _____ Effective _____
Policy Holder _____ Relationship to You _____

Primary Care physician you have listed with your insurance carrier _____
Whom may we thank for referring you to our practice? _____

TELEPHONE NOTIFICATION CONSENT

Due to our concern for your confidentiality, we are asking that you sign a release to advise us how we may contact you.
Please select one or more options.

I give permission for office staff to call and identify themselves as calling from South Shore Women's Health Care and leave detailed information regarding my appointment schedule, test results, prescriptions or care on my answering machine:

- At Home # _____
- At Work # _____
- Cell Phone # _____
- Do not phone me. I understand I will receive all (urgent and non-urgent) notifications and reminders by mail only.

I also give permission for office staff to speak with the following individual(s):

Signed _____ Date _____

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, as discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation, an identification of a dead body, a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another physician or other health care professionals, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

PATIENT ACKNOWLEDGEMENT

Please sign this form below under the heading 'acknowledgement' to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Patient Signature

Patient Name—Please Print

Date: _____

Patient Consent

Please sign this form below under the heading 'Consent' to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment.

Patient Signature

Patient Name—Please Print

Date: _____

For Office Use Only: Patient refused to sign the Acknowledgement due to the following circumstances: _____

Financial Policy

INSURANCE – You must provide your insurance card at the time of service, and we ask that you inform us of any changes to your address, phone number, employment status, or insurance coverage. If you do not have the information requested, i.e. insurance cards, we may ask you to reschedule your appointment or pay in full at the time of service. We will only accept Medicaid as secondary insurance to a commercial insurance that we participate with, or Medicare. We do NOT accept Medicaid as a primary insurance and will NOT retroactively bill any service to Medicaid once presented as secondary. We will only accept Michigan Medicaid as a secondary insurance from the date it is presented forward. If circumstances arise that you are only covered by Medicaid; you have the option to waive the Medicaid benefits at our office, or you will be expected to transfer your care to a Provider that accepts Medicaid payment.

CO-PAYS, DEDUCTIBLES, & NON-COVERED SERVICES – All co-payments, deductibles and non-covered services are due at the time of service. We cannot waive co-pays or deductibles as this would be a breach of contract between you and your insurance carrier.

CLAIM SUBMISSION – We will submit to all insurance companies as a courtesy. If we do not participate with your insurance carrier, you will be expected to pay in full at the time of service as your insurance will reimburse you directly if you have the appropriate benefits for the services performed.

NON-PAYMENT – If your account becomes 90 days past due, you will receive a pre-collection letter. Your medical care is our priority and your compliance with financial responsibilities is appreciated. If however, your account remains unpaid and we forward your account to an outside collection agency, the account will be assessed a 40% collection fee of the remaining balance.

RETURNED CHECK – In the event that we receive a returned check due to insufficient funds, or a stop payment; a \$30 fee will be assessed to your account.

INSURANCE FORMS, MEDICAL RECORDS & DISABILITY FORMS – We charge an administrative fee for completing insurance forms, copying medical records and disability verification forms. We request 7-10 business days to complete.

FORMS OF PAYMENT – We accept CASH, CHECK, MONEY ORDER, MASTERCARD, VISA & DISCOVER.

CANCELLATION/NO SHOW POLICY – We ask if you need to cancel or reschedule an appointment, that you do so 24 hours prior to your scheduled time. Our “No Show” policy allows you to miss one appointment. If you should miss a second appointment, a \$25.00 charge will be added to your account that must be paid in full before future appointments.

I understand and agree that I will be financially responsible for services provided to me and all costs of collection incurred by the practice should my account be determined delinquent (approximately 40% of past due balance). I have provided the practice with all of my insurance coverage and will keep this office informed if my coverage changes. I have read and understand the policies and how they affect me and my financial obligations to the practice.

Release of Authorization – I authorize the release of any medical information necessary to process my insurance claims. I understand and agree that I am responsible for all charges not authorized by my insurance carrier.

Date: _____ Patient Name
(Printed): _____

Financially Responsible Party (Printed):

If Minor, or other than Patient

Signature:

SOUTH SHORE WOMEN'S HEALTH CARE

Notice Regarding No-Show Appointments:

In order to improve efficiency, SSWHC has created the following policy regarding No-Show appointments:

We understand the demands on time and realize how easy it is to miss an appointment. **Our No-Show policy allows you to miss one appointment.** If you should miss a second appointment, a \$25.00 charge will be added to your statement.

We do ask that if you need to cancel or reschedule an appointment, that you do so 24 hours prior to your scheduled appointment, so that the appointment can be offered to other patients.

We ask that the \$25.00 fee be paid in full prior to scheduling any further appointments.