ASSOCIATES IN WOMENS HEALTH

K. KHAGHANY MD FACOG CORINNE DIROFF CNM S. MOSSALLAM DO FACOG NATASHA WELKER CNM

Women's Health Physicians Board Certified in Obstetrics and Gynecology

PATIENTS' INFORMATION SHEET

Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently.

Last Name: _____ First Name: _____

Soc. Security #: _____ Date of Birth: _____ Marital Status: S M W D

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: (___) _____ Cell Phone #: (___) _____

Email Address: _____ Emergency Contact #:(___) _____

Employer: _____ Work Phone #:(___) _____

Primary Care Physician: _____ Phone #:(___) _____

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____ Relationship to Patient: _____

Address (if other than patient): _____

Home Phone #: (___) _____ Soc. Security #: _____

Employer: _____ Work Phone #: (___) _____

INSURANCE INFORMATION

KINDLY PRESENT ALL INSURANCE CARDS TO RECEPTIONIST

Primary Insurance: _____

Insured's Name: _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Social Security #: _____ Date of Birth: _____ Sex: Male / Female

If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank You!

Secondary Insurance: _____

Insured's Name: _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Social Security #: _____ Date of Birth: _____ Sex: Male / Female

It is your responsibility to be familiar with the terms, deductibles, referral requirements, and co-pays of your insurance company. Failure to provide us with the correct insurance information or follow their guidelines may result in **NON-COVERED** expenses, which will become your responsibility. If the Doctor doesn't participate with your insurance company, payment is due at the time of service and claims can be submitted for your reimbursement.

My signature below attests to the following: I have read these statements and wish to proceed with my exam/visit today, knowing I may be responsible for a portion or all of the charges. I agree to pay Associates in Women's Health PLLC (Drs.Khaghany, Mossallam and Corinne Diroff, CNM) for services not covered by my insurance company, co-pays, or deductibles. I authorize the release of any medical information necessary for my insurance company to process this claim. I also authorize payment of medical benefits to the physician for services rendered. I also authorize any pictures I send in or give to the above Providers to be displayed thru out the office of AIWH.

Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

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Medical History

Name:_____ Date of Birth:_____

Primary Care Provider:_____

Pharmacy:_____ Mail order Pharmacy:_____

Do You Smoke? Y N Start date:_____ □ Cigarette □ E-cig □ Marijuana
□ Never Smoker

Alcohol: Y N Light – Moderate – Heavy

Medication Allergies:

_____

_____

Medications taken Currently:_____

_____

_____

_____

Do You Take Narcotic Pain Medications? Y N

Name of Medications:_____

Reason For taking/ Length of time on medication:_____

_____

OB/ GYN
Last Menstrual Period:_____ Are Your Periods: Painful: Y N Heavy: Y N Irregular: Y N
Total Pregnancies:_____ Births:_____ Miscarriages:_____ Abortions:____
Last Pap Smear:_____ History of Abnormal Pap Smear: Y N
Cervical Colposcopy: Y N Year:____ Leep/Cryo/Cone Biopsy: Y N Year:_____
History of Abnormal Biopsy: Y N
History of: Chlamydia, Gonorrhoea, Genital Herpes, Genital Warts
Other:_____
Sexually Active Y N

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Bladder Health
History of Urinary Tract Infections: Y N
Are you Having Problems With: Urinary Urgency or Frequency? Y N
Are You Having any Leakage of Urine? Y N

Patient or Family History of:

	Patient	Family
Anemia	☐	☐
Anxiety	☐	☐
Asthma	☐	☐
Blood Clots	☐	☐
Constipation	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Glaucoma	☐	☐
Heart Disease	☐	☐
Hemorrhoids	☐	☐
High Blood Pressure	☐	☐
Kidney Stones	☐	☐
Migraines	☐	☐
Osteoporosis	☐	☐
Seizures	☐	☐
Thyroid Dysfunction	☐	☐
Ulcers	☐	☐

Patient or Family History of Cancer:

	Patient	Family
Bladder	☐	☐
Colon	☐	☐
Skin	☐	☐
Ovarian	☐	☐
Uterine	☐	☐
Breast	☐	☐

Age When Diagnosed (Breast Cancer Only)
♦Mother _____
♦ Grandmother _____
♦ Aunt _____
♦ Sister _____

Any History of Abuse: Sexual - Verbal - Physical

Surgical History

Year Operation

_____

_____

_____

_____

Date Completed:_____

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ADVANCE DIRECTIVE EDUCATION

Patient Name: _____ Date: _____

Associates in Womens Health is required by the federal and state laws to educate all patients 18 years and older on *Advanced Directives and self determination policies*.

An Advanced Directive document indicates and stipulates a person's choice of treatment should they become mentally unable to make decisions for them self due to injury or illness. A living will, durable power of attorney, or codes status in case of emergency are some of the choices that illustrate an Advanced Directive. It allows the person to state how medical decisions are to be made when his/her ability is lost.

1. Do you have a will or Advanced Directive?

   _____ Yes _____No
2. Do you want information on Living Wills and Advanced Directives?

   _____ Yes _____ No

3. Education materials on Advanced Directives given to patient.

   _____ Yes _____ No Date: _____

Patient Signature: _____ Date: _____
Staff Signature: _____ Date: _____

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As of August 2013, Associates in Womens Health will no longer be held responsible for any bill that may accumulate on your patient account that has resulted due to incorrect information. It is each patient's responsibility to provide our office with any new changes in insurance. We will not back bill or re-bill any balance that has accumulated due to wrong or old information being in our billing system. Providing all correct information each visit is your responsibility. Again, failure to do so may result in the bill being your responsibility.

By signing this form I understand that it is up to me to provide Associates in Womens Health with all accurate information. This includes all updates involving phone numbers, change of address, and insurance information.

Patient Signature _____ Date _____

Staff Signature _____ Date _____

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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 acknowledgment, 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 doctor or other health care professional, 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: _____

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing this Acknowledgement:

_____

_____

An emergency situation prevented the patient from signing the Acknowledgement.

_____ _____

Office Personnel (signature) Office Personnel (print name)

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 the proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____ _____

Patient Signature Patient Name (please print)

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Practice Policies – Agreement of Care

The following document is an agreement of care and office practice policies. This agreement is made between _____ (patient) and *Associates in Womens Health* on this date _____ / _____ / _____.

If you are unable to keep a scheduled appointment, it is your responsibility to cancel or reschedule your appointment at least 24 hours prior to the scheduled visit. You are required to follow all of the care instructions and orders, and to have all blood work and radiological testing performed in a timely manner. If you fail to keep 2 scheduled appointments, you will be given a letter of notice. If you fail to keep 3 scheduled appointments you will be asked to find another health care provider. If you have a change in insurance you will need to provide us with that information in a timely fashion. Failure to bring your insurance card at time of visit will result in you having to reschedule your appointment. If you no longer have health care coverage, you will be charged the self-pay rate for each visit at time of service.

It is our office policy that we will notify you of any abnormal test results, first by phone, in the event that the office has to leave a message, we will wait 48hrs for a returned phone call from you. If you fail to return our call we will then send you a letter stating you have an abnormal test. The results will not be in the letter. You can call our office to inquire on your test results only normal test results will be given out, but please allow 5 working days.

Copays are due at the time of service.

Your signature on this document indicates that you have read the information in its entirety, and that you agree to the practice policies and terms.

Printed Name: _____ Date: _____

Signature: _____

Witness: _____

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I, _____ have no history of substance abuse. If at any time substance abuse is evident, I understand that I could be discharged from Associates in Womens Health. Our office is committed in providing the best women's health possible, but in order to do this we need your help by being honest with all medical history. As always, we value you as a patient and your health is our first priority.

Below is a list of the things that Associates in Womens Health consider to be substance abuse.

Pain Medication: If yes please list the drug(s) below

Narcotics: If yes please list the drug(s) below

Patient Signature: _____ Date: _____
Witness Signature: _____ Date: _____

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