WOMENS SPECIALTY ASSOCIATES
ANNUAL PATIENT INFORMATION FORM

PATIENT NAME_____ DATE OF BIRTH_____ AGE_____

SOCIAL SECURITY NUMBER_____ MARITAL STATUS_____

ADDRESS_____ APT_____ CITY_____ STATE_____ ZIP_____

HOME PHONE (____) _____ CELL PHONE (____) _____ Text appointment reminders? Yes___ No___

EMPLOYER_____ FAMILY DOCTOR_____ PHONE (____) _____

SPOUSES NAME_____ DATE OF BIRTH_____ PHONE NUMBER (____) _____

HEALTH INSURANCE_____ SUBSCRIBERS NAME_____ D.O.B_____

SUBSCRIBERS SOCIAL SECURITY NUMBER_____ SUBSCRIBERS EMPLOYER _____

EMERGENCY CONTACT NAME_____ PHONE (____) _____ RELATIONSHIP_____

PHARMACY NAME_____ PHONE NUMBER (____) _____

RACE: African American Asian Caucasian Hispanic Other_____ Refused

PRIVACY STATEMENT:

We protect our patient's information and the record that we have about their health and the services received in our office. We must have your written, signed consent in order to disclose your health information to your family doctor, insurance company (including disability claims) for the purposes of your treatment, the payment of your bills, appointment reminders, etc. I have received a copy of the Privacy Notice.

(HIPAA- 164.520 © Effective 04/14/2003) *To be filed and retained for a minimum of six (6) years.

Signature_____ Date_____

Please list the family member or persons, if any, whom we may inform about your general medical condition and diagnosis.

_____ _____

_____ _____

Can we leave a confidential message about your care on your answering machine/voice mail? _____

Do you have an authorized power of attorney? Yes___ No___ Do you have an advanced directive? Yes___ No___

Would you be interested in information about advanced directives? Yes___ No __

→ **FINANCIAL RESPONSIBILITY**: I authorize the release of medical information to insurance carriers concerning my illness and treatment. I hereby assign to the doctor all payment for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by insurance and that I will pay any co-pays on the date of service unless other arrangements are made. I understand that each statement sent without payment will accrue a $3 fee. I understand if I no-show to an appointment I will be charged a $25 fee that must be paid to make another appointment. *Please note a 3.99% processing fee is applied to all credit and debit transactions

RESPONSIBLE PARTY SIGNATURE_____ DATE _____

→ **MEDICARE AUTHORIZATION:** I request that payment of authorized Medicare benefits be made to Women's Specialty Associates on my behalf. I authorize the holder of my medical information to release to the HCFA and their agents any information needed to determine these benefits for related services. I understand that HCFA is the government Medicare agency.

Signature: _____ Date: _____

WOMEN'S SPECIALTY ASSOCIATES, P.C.

Obstetrics and Gynecology

Dr. Carol Powers
Dr. Alisa Wolner Dr. Julianna Friesen
Dr. Sarah Hopkins

Our goal as your physician is to provide you with professional, high quality and effective care. In order for us to achieve timely consultations and enhanced quality of care, we need to work closely with your primary care physician and any other specialist.

Do you have a primary care physician? ☐ Yes ☐No

If yes, who is your primary care physician?

Doctor's Name: _____
FIRST *LAST*

Address: _____

_____

Do you authorize us to access your previous prescription history?

☐ Yes ☐No

Do you authorize us to provide your primary care physician with our medical recommendations and care you have been receiving in our office? ☐ Yes ☐No

***Please note if your insurance is managed care or an HMO we are required to communicate with your primary care physician due to referral process.**

If no, please explain why: _____

_____

I have read and understand the information provided in regards to My Medical Neighborhood (see back). I have been counseled on the importance of continuity of care between myself (the patient), my primary care physician and the specialist(s).

Patient signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____

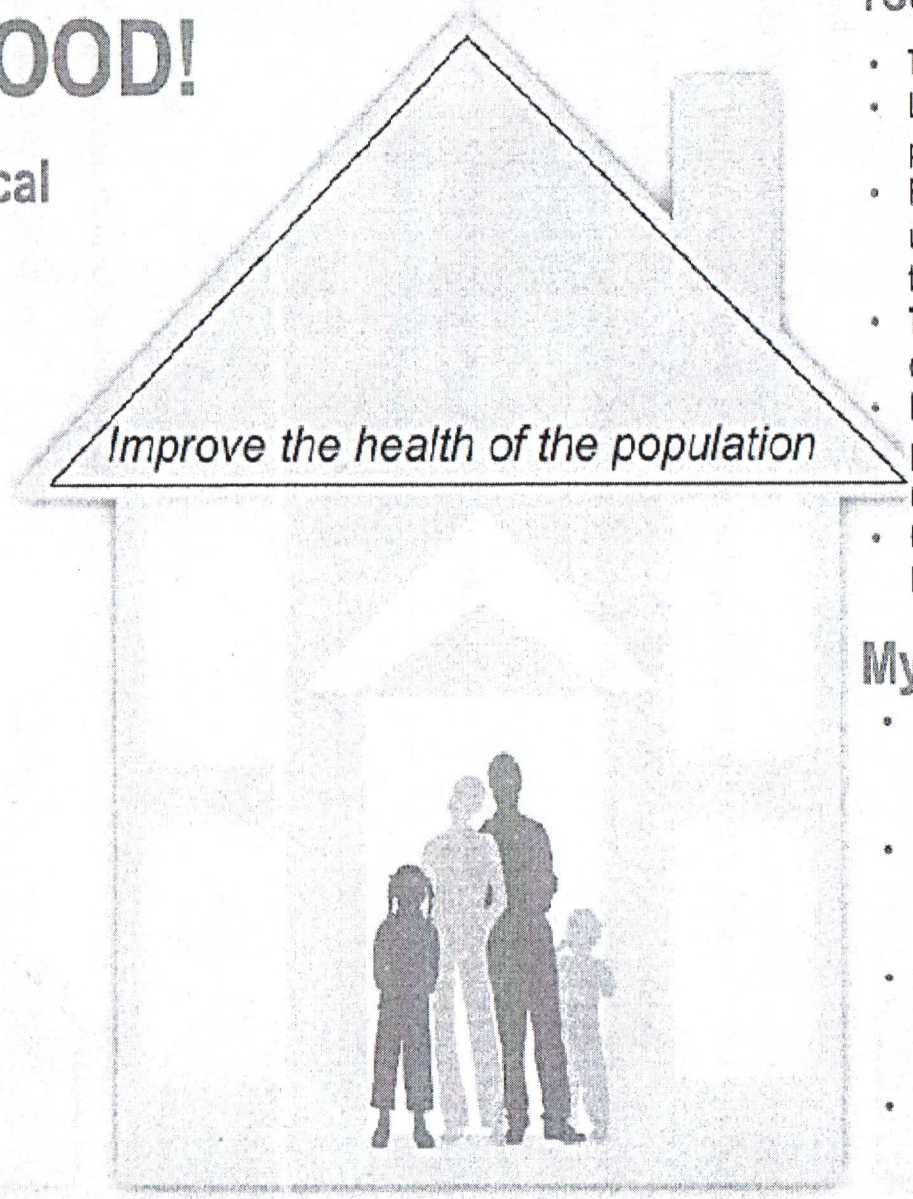
3434 Regency Park Drive, Grand Blanc MI ▪ Phone 810-694-9400 ▪ Fax 810-694-9445

WE ARE PART OF YOUR MEDICAL NEIGHBORHOOD!

Patient Centered Medical Neighborhood

A Patient Centered Medical Home (PCMH) is a team approach to providing comprehensive healthcare to patients in a high quality and cost effective manner.

The Medical Neighborhood is an expansion of the PCMH model connecting primary care physicians, specialty practices, hospitals, and other community health services to work together more efficiently in meeting the specific needs of each patient.



Your Role As the Patient...

- Take part in planning your care
- Learn about wellness and how to prevent diseases
- Follow the care plan that is agreed upon and receive the recommended treatment
- Tell us any prescribed or over the counter medications you are taking
- Have all other physicians who take part in your care send us a report regarding your visit to them
- Continue to see your Primary Care Physician for preventive services

My Role As the Physician...

- Provide you with care that meets your needs and fits with your goals and values
- Work closely with your Primary Care Physician and other Specialists to provide coordinated care
- Ensure efficient flow of information, including timely consultations, referrals and test results
- Support enhanced access and patient-centered, high quality care

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