WELCOME

Dear Patient:

Welcome to Alliance Obstetric & Gynecology, PLLC. You are scheduled for an appointment as follows:

Date:	Time:	Arrive by:
Provider:	Location: ○ Main Campus – East Lansing ○ South Campus - Mason	

In this packet you will find all the forms that **must be completed prior to arriving**.

The following is a list of items you will need to have completed and bring with you to your appointment.

- **Patient Information (Page 2 of this document)**
- **Financial Policy (Page 3 of this document)**
- **Alliance OB/GYN Medical History (Pages 4-7 of this document)**
- **Confidential Communication of Protected Health Information (Page 8 of this document)**
- **Valid Picture ID (Driver's License/State ID)**
- **Insurance Card(s)**

PLEASE BE AWARE THAT RESCHEDULING WILL BE NECESSARY IF THE FORMS ARE INCOMPLETE AND/OR FAILURE TO ARRIVE 30 MINUTES PRIOR TO THE APPOINTMENT TIME.

If you are being referred to us by a physician or have an ongoing problem, please have the pertinent portion of your medical record forwarded to our office. If you are a self referral and have no ongoing problems, we do not need a copy of your medical records forwarded.

Prior to your office visit, please check with your insurance company to see if an authorization is required for your appointment. Also, please bring your insurance card so that we may copy it for our records.

This appointment time has been set aside for you and the provider to discuss your care. If you are unable to keep this appointment please notify our office 24 hours prior to your appointment. If you do not cancel your appointment in the designated time we may be unable to reschedule your appointment.

Thank you for choosing Alliance Obstetrics and Gynecology, PLLC for your health care.

BRING COMPLETED FORM TO APPOINTMENT

PATIENT INFORMATION						
Family Physician:					Phone:	
Referring Physician:					Phone:	
Patient's last name:	First:	Middle:	Preferred to be called:	Marital Status:		
				Single	Married	Divorced
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Cell Phone: ( )		Home phone: ( )		
P.O. box / Apt #:	City:	State:	Zip Code:	Social Security Number: - -		
Employer:				Employer phone no.:		
Ethnicity:		Race:		Language:		
Preferred Notification Method:	❑Phone	❑ Postal Mail	❑ Portal	Email Address:		

INSURANCE INFORMATION COPIES OF CURRENT INSURANCE CARD(S) WILL BE REQUESTED		
PRIMARY INSURANCE:	Subscriber Date of Birth:	Patient's relationship to subscriber:
Subscriber's Name:	Subscriber SS#:	Subscriber's employer:
SECONDARY INSURANCE:	Subscriber Date of Birth:	Patient's relationship to subscriber:
Subscriber's Name:	Subscriber SS#:	Subscriber's employer:

EMERGENCY CONTACT		
Name of local friend or relative:		Relationship to patient:
Cell Phone:	Home phone no.:	Work phone no.:
( )	( )	( )

I hereby authorize the release of any medical information necessary to process my insurance claim. I authorize payment to be made directly to Alliance Obstetric and Gynecology, TIN #38-3381725. I have been provided with a copy of the Alliance Financial Policy and understand that I am financially responsible for any balance not covered by my insurance carrier.

Patient / Guardian Signature **Date**

To All Patients,

The purpose of this document is to help patients understand medical insurance, eligibility, coverage, and medical services as well as to inform them about their financial responsibility

It must be understood:

- We render our services based on medical guidelines , not Insurance benefits
- Not all insurance companies/third party payers pay for all services, each policy has its own particular benefits regarding covered services, or amount of coverage
- All insurance companies state that verification of coverage is not a guarantee of coverage or payment. Actual benefits are determined by your insurance company after a claim is received
- Patients are responsible for **knowing** and **understanding** their own Insurance Policy, Eligibility and Coverage

Financial Responsibility:

- Patients are responsible for payment of **outstanding** balances (Deductibles, Co-insurance and non-covered services, etc.) at the time of service. Co-pays will be collected at the time of service.
- Patients are responsible for full payment on Deductibles, Co-insurances, Co-payments, services deemed as "not a benefit" and "non-covered" services
- Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred.
- Medicare patients may be asked to sign an Advances Beneficiary Notice (ABN) form as required by Medicare for certain services
- Changes in insurance coverage must be reported to our Billing Staff promptly.
- There is a $25 fee for Medical records requests. Payment for these records will be collected prior to records being released. If applicable, a complimentary copy of your records will be sent to the physician of your choice.
- Any appointment missed or not cancelled more than 24 hours in advance will incur a $75.00 charge
- Returned checks are subject to a $35.00 fee
- We reserve the right to turn any account over to a collection agency for collection if it is deemed that the account has been in default or noncompliance with this policy.
- By signing this document, the Patient or Patient's Representative authorizes Alliance Obstetrics & Gynecology and its third party billing and/or collection service providers to use any and all information provided by the Patient or Personal Representative for contact, including cell phone, if required.

SIGNATURE WILL BE OBTAIN AT REGISTRATION

BRING COMPLETED FORM TO APPOINTMENT

MEDICAL HISTORY - CHECK ALL THAT APPLY TO YOU

Breast

- ☐ Breast Lump (benign)
- ☐ Breast Cancer
- ☐ Fibrocystic Disease of the breast
- ☐ Cyst of the Breast
- ☐ Nipple discharge
- ☐ Mastitis
- ☐ Breast Infection

Cancer

- ☐ Brain Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ Ovarian Cancer
- ☐ Rectal Cancer
- ☐ Skin Cancer
  Type: _____
- ☐ Stomach Cancer
- ☐ Thyroid Cancer
- ☐ Uterine Cancer
- ☐ Other Cancer
  Type: _____

Cardiovascular

- ☐ Blood Clot
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Hypercholesterolemia
- ☐ Peripheral Vascular Disease
- ☐ Pulmonary Embolism
- ☐ Raynaud's Syndrome
- ☐ Rheumatic Heart Disease
- ☐ Heart Problem
  Type: _____

Dermatological

- ☐ Acne
- ☐ Ulcer of the skin
- ☐ Lupus

Endocrine

- ☐ Goiter
- ☐ Graves' Disease
- ☐ Hashimoto Thyroiditis
- ☐ Hypothyroidism
- ☐ Thyroidectomy (circle one)
  - o Partial
  - o Full
- ☐ Gestational Diabetes
- ☐ Diabetic
  - o Insulin dependent
  - o Non-insulin dependent
- ☐ Polycystic Ovarian Disease

Gastrointestinal

- ☐ Cholelithiasis
- ☐ Crohn's Disease
- ☐ Diverticulitis of the colon
- ☐ Cirrhosis of Liver
- ☐ Gastric Ulcer
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Ulcerative Colitis
- ☐ Acute Hepatitis
- ☐ Viral Hepatitis A
- ☐ Viral Hepatitis B
- ☐ Viral Hepatitis C
- ☐ Hemorrhoids

Genitourinary

- ☐ Endometriosis
- ☐ Infertility
- ☐ Ovarian Cyst
- ☐ Kidney Disease
- ☐ Chronic Cystitis
- ☐ Kidney Stones
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Lichen Sclerosis
- ☐ Premenstrual Dysthymic Disease
- ☐ History of Abnormal Pap
  Type: _____
- ☐ Interstitial Cystitis
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Genital Warts
- ☐ Herpes-Genital

Menstrual History

- ☐ Last menstrual period: _____
- ☐ Bleeding or spotting between periods
- ☐ How heavy is your flow during periods?
  - ☐ Light ☐ Moderate ☐ Heavy
- ☐ Do you have clotting during your periods?
  - ☐ Yes ☐ No
- ☐ Do you have painful cramping during your periods?
  - ☐ Yes ☐ No

HEENT

- ☐ Deafness
- ☐ Blindness
- ☐ Glaucoma
- ☐ Migraine with aura
- ☐ Migraine w/o aura

Hematological

- ☐ Anemia
- ☐ Sickle Cell Anemia
- ☐ DVT/Pulmonary Embolism
- ☐ Hemophilia
- ☐ Von Willebrand's Disease
- ☐ Transfusion
- ☐ Thrombophilia or clotting disorder

Musculoskeletal

- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Osteopenia
- ☐ Osteoporosis

Neurological

- ☐ Migraine
- ☐ Migraine with aura
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Myasthenia Graves
- ☐ Stroke
- ☐ Seizure Disorder

Psychiatric

- ☐ Alcohol Abuse
- ☐ Anorexia Nervosa
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ OCD
- ☐ Schizophrenia
- ☐ Suicide Attempt
- ☐ Post-Partum Depression
- ☐ Bulimia Nervosa
- ☐ Borderline Personality Disorder

Respiratory

- ☐ Asthma
- ☐ COPD

BRING COMPLETED FORM TO APPOINTMENT

SURGICAL HISTORY – PLEASE CHECK ALL THAT APPLY – INCLUDE DATES

Type of Surgery	Year(s):
☐ D&C	
☐ Ovarian Surgery – Type: _____	
☐ Hysteroscopy Removal of Polyp or Fibroid (circle one)	
☐ Laparoscopy	
☐ Myomectomy	
☐ Infertility Surgery	
☐ Vulvar Surgery – Type: _____	
☐ Hysterectomy – Vaginal	
If yes, do you? ☐ Still have cervix ☐ Still have both ovaries ☐ Still have one ovary	
☐ Hysterectomy – Abdominal	
If yes, do you? ☐ Still have cervix ☐ Still have both ovaries ☐ Still have one ovary	
☐ Cesarean Section	
☐ Tubal Ligation (tubes tied)	
☐ Vaginal or Bladder Repair for Prolapse or Incontinence	
☐ Endometrial Ablation	
☐ **Other Surgeries – Please list with year**	

ALLERGIES TO MEDICATIONS		**IMMUNIZATIONS – Indicate the date of your:**	
☐ **NO, I do not have allergies to medications**		Last Tetanus Shot	
☐ **YES, I have allergies to medications as listed below**		Last MMR Shot (measles)	
Medication	**Reaction**	Last Flu Shot	
		Last Pneumonia Shot	
		Last Shingles Shot	
		Last Varicella (chicken pox) Shot	
		Last Gardasil (cervical cancer) Shot	
Iodine Allergy ☐ Yes	☐ No		
Latex Allergy ☐ Yes	☐ No		

FAMILY HISTORY

Please only indicate First Degree Relative(s)

First Degree Relative is defined as a family member who shares about 50 percent of their genes with a particular individual in a family.

First degree relatives include parents, offspring, and siblings.

	Mother	Father	Brother	Sister	Maternal - Aunt	Maternal - Uncle	Paternal - Aunt	Paternal - Uncle	Cousin	Maternal - Grandmother	Maternal - Grandfather	Paternal - Grandmother	Paternal - Grandfather	Other
Diabetes - Insulin Dependant														
Diabetes - Non-Insulin Dependant														
Heart Disease														
Breast Cancer														
Ovarian Cancer														
Uterine Cancer														
Colon Cancer														
Blood clots (leg/lungs)														
Thrombophilia														
Stroke														
Hypertension														
Other: _____														

BRING COMPLETED FORM TO APPOINTMENT

SOCIAL / SEXUAL HISTORY

Occupation: _____ Marital Status: ___ Living Situation: _____

Are you currently using or participating in the following:

Tobacco (chewing or smoking)	Yes	No	How frequently? _____	Amount: _____
Second Hand Smoke Exposure	Yes	No	How frequently? _____	Type: _____
Alcohol	Yes	No	How frequently? _____	Amount: _____
Illicit Drugs	Yes	No	Type: _____	Amount: _____
Exercise	Yes	No	How often? _____	Type: _____
Birth Control	Yes	No	Type: _____	(i.e. IUD, pills, condom, etc)
Have you ever been sexually active?	Yes	No		
Are you currently sexually active?	Yes	No	Number of partners currently? _____	
Please indicate, are you sexually active with:			o Male o Female o Both o Decline	
History of abuse?	Yes	No	Check all that apply: o Physical o Mental o Verbal	
Are you currently being abused?	Yes	No		

Are there religious beliefs affecting medical care?	Yes	No
Are you agreeable to receiving blood/blood products	Yes	No

Other (please specify):

SAFETY HISTORY

Do you wear a helmet?	Yes	No
Do you wear a seat belt?	Yes	No

CURRENT DAILY MEDICATIONS, VITAMINS AND OVER THE COUNTER SUPPLEMENTS (attach additional list if needed)

Medication	Dose (amount)	Frequency (how often taken)

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HISTORY OF PREGNANCY ☐ **Never been pregnant, skip to Health Maintenance.**

Total # of Pregnancies:	Total # of Deliveries:	Total # of Pre Term Deliveries:	Total # of C-Sections:
Total # of Miscarriages:	Total # of Abortions:	Total # of Live Births:	Total # of Ectopic Pregnancy:

Have you had any of the following during pregnancy:

☐ Gestational Diabetes	☐ Fetal Demise
☐ Preeclampsia	☐ Placental Abruption
☐ Multiple Gestation Twins	☐ Hemorrhage
☐ Multiple Gestation Triplets	☐ Pre-Term Labor

HEALTH MAINTENANCE

	Date	Result
Last Mammogram		
Last Colonoscopy		
Last Bone Density		
Last Pap		
Last HPV		
Have you ever had an abnormal pap? Yes No		Year:

Have you ever had treatment for an abnormal pap smear?			Yes No	If yes, what type of treatment have you had?
	☐ Cryotherapy	Year:		
	☐ Laser	Year:		
	☐ Cone Biopsy	Year:		
	☐ Loop excision (LEEP)	Year:		
Have you had BRCA screening (blood test for breast cancer gene)?			Yes No	

Do you need assistance with your visit? (i.e. wheelchair, interpreter service, etc): _____

_____

_____

Alliance Obstetrics & Gynecology, PLLC
1560 Turf Lane, East Lansing, MI 48823
P: 517.484.3000 F: 517-484-6358

Confidential Communication of Protected Health Information

Patient Name (please print) _____

SSN (last four digits):_____ **Date of Birth:**_____ **Account #**_____

☐ **OPTION 1** - I authorize Alliance Obstetrics & Gynecology, PLLC to disclose or provide protected health information, about me, to individual(s) listed below:

Name: _____ Relationship:_____ Phone: _____

I authorize the practice to disclose the following protected health information to the individual listed above.

☐ Entire record ☐ Billing information ☐ Office Notes ☐ Labs or ultrasound

Name: _____ Relationship:_____ Phone: _____

I authorize the practice to disclose the following protected health information to the individual listed above.

☐ Entire record ☐ Billing information ☐ Office Notes ☐ Labs or ultrasound

Name: _____ Relationship:_____ Phone: _____

I authorize the practice to disclose the following protected health information to the individual listed above.

☐ Entire record ☐ Billing information ☐ Office Notes ☐ Labs or ultrasound

- This authorization will expire 3 years from date of signature in which the authorization was initiated, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the 3 year expiration date:_____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

☐ **OPTION 2** - I decline to authorize Alliance Obstetrics & Gynecology, PLLC to disclose or provide protected health information about me to any individual(s).

_____

Patient signature **Date**

Copies of signed authorizations are available upon request

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