**Contact Information**

Your Name (First and Last):

Date of Birth:

Full Address:

Cell Phone:

Alternate Phone (if wanted):

Email Address:

Marital Status:

Your SS# (or last 4 digits):

**Insurance Information**

Name of Insurance:

Name of Subscriber and Their Relationship to You:

ID # or Enrollee ID:

Group #:

**\*IF POSSIBLE- PLEASE EMAIL A PICTURE OF YOUR INSURANCE CARD (front and back) TO** [**huronvalleyob@gmail.com\***](mailto:huronvalleyob@gmail.com*)

**Other Information**

Emergency Contact Name:

Emergency Contact Phone Number:

Primary Care Physician’s Name:

Primary Care Physician’s Number:

Pharmacy Name:

Pharmacy Number:

If you are a new patient, how did you hear about us?:

**Medical History**

Allergies or Sensitivity to Medications:

Medications You are Currently Taking:

Do You Smoke?

Do You Drink Alcohol?

Are You Pregnant?

Please indicate any of the following that you have had or presently have:

Abnormal Uterine Bleeding

AIDS

Addiction (please specify)

Anemia

Angina

Arthritis

Blood Transfusion

Bruise Easily

Chemotherapy

Cortisone Medicine

Diabetes

Emphysema

Fainting/Dizziness

Glaucoma

Heart Disease or Murmur

Heart Surgery

Hemophilia

High Blood Pressure

Kidney Trouble

Liver Disease

Nervousness

Phlebitis

Psychiatric Disorders

Radiation

Rheumatic Fever

Stroke

Thyroid Disease

Tuberculosis

Ulcers

Venereal Disease

Hospitalizations:

Surgeries:

**Authorization/Responsibility Agreement**

**\*Please type your name and date after each to signify that you understand and agree to our billing and notification policies\***

I have requested Dr. Miller to bill my insurance company (for covered services) on my behalf. I clearly understand that it is my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt payment of my bill.

**\*NAME AND DATE:**

In order to process claims for benefits, I authorize Dr. Miller to release any of my information regarding my medical history, symptoms, treatment, examination results of diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original.

**\*NAME AND DATE:**

Our Notice of Privacy Practices, which is standard HIPAA protocol, is available on our website. It outlines our legal duty for use and disclosure of your medical information, as well as your individual rights to your medical records. If you want to read this, please go our website [www.huronvalleyobgyn.com](http://www.huronvalleyobgyn.com) and click on the “Forms” tab. It will be under “Notice of Privacy Practices”. Or we can email it to you if you prefer. Please enter your name and date to signify that you have been provided an opportunity to read and review this document.

**\*NAME AND DATE:**

**Release of Information to Anyone Other than Yourself**

Due to HIPAA regulations, your privacy and the protection of your medical information is an extremely high concern for us. We understand that sometimes mothers, fathers, husbands, sisters etc…would like to call and check on times of your appointments or even talk to the doctor about concerns they are having. We are not allowed to release **ANY information** without your consent to individuals who are not medical professionals and under the same HIPAA oath. Please list anyone below that you would like to be able to check on the time of your appointment, pick up medical records or prescriptions for you, or can talk to the doctor about your personal medical information. This does not mean that these people will have full disclosure to your records; however, we will be able to share information with them if they ask. These people are also not allowed to sign record releases for you. That is something that must be done in person by you.

Names & DOB of Persons you would allow us to release information contained in your chart to:

Please type your initials after each policy to signify you understand and agree. Then type your name and date at the end. Thank you ☺

Office Policies

* Please arrive at least 5 minutes prior to your scheduled appointment time. This allows the receptionist and nurses to get you back into a room in a timely manner and allows appointments to run on time**. \*INITIAL HERE**:
* If you are running late, please call our office and let the receptionist know. We will do our best to still see you but there may be a need to reschedule. **\*INITIAL HERE**:
* If you are late or do not show for an appointment 3 times in a row, there will be a $25 late fee. If you call the receptionist and cancel ahead of time or let them know you will be running late, that appointment will not be counted against you**\*INITIAL HERE**:
* Unless prior arrangements are made, your full balance and copay are due at the time of the appointment. Copays can be billed one time, but there will be a $5 surcharge if the copay isn’t paid at the time of the visit. If you cannot pay this amount and need to be seen, please contact the billing department. **\*INITIAL HERE**:
* Any paperwork that needs to be filled out or copied must be left with the receptionist. That is done on Tuesday afternoons between the hours of 2-4 when there are no doctors or patients in the office. If the receptionist is able to do so prior to Tuesday afternoon, she will call you and let you know. Please understand there is a large volume of paperwork that is asked to be done, and therefore your patience is appreciated. **\*INITIAL HERE**:
* Regarding paperwork (such as FMLA, disability, AFLAC), the first set of papers we would be happy to do free of charge. Again, these are done on Tuesday afternoons. However, if you have more than one set, each additional set of paperwork will be $10 per packet. **\*INITIAL HERE**:
* Copying of records is done on Tuesday afternoons. Requests such as doctors notes, dentist notes, records requested from primary doctors or other specialists will be done free of charge. If you are changing doctors and are requesting your records to be copied and sent, 10 pages or less will be free of charge. A $25 dollar charge is applicable for anything above that amount. **\*INITIAL HERE**:
* Regarding the use of cellular phones in the office- due to equipment, we ask that you turn off your cell phone when brought back from the lobby. The use of cell phones is permitted in the lobby; however for common courtesy please discontinue calls when talking to the receptionist or when the nurse calls you back. We appreciate your cooperation. ­­­**\*INITIAL HERE**:
* Please understand that there are hundreds of insurance policies. While we do our best to be aware and familiar with these policies, it is impossible to know the intricacies of each and every one. It is your responsibility to understand your particular policy. We will be happy to assist you with any billing questions once you have talked to your insurance provider. **\*INITIAL HERE**:
* Finally, it is very important that you give us an accurate phone number when making your appointments. This number needs to be where you can be reached before your appointment. Both physicians can be called out on a minutes notice for a delivery. We will use the number you give us at the time to make your appointment to reach you to reschedule. If no one answers, a message will be left. Please check your answering machine before coming to an appointment. **\*INITIAL HERE**:

I understand and agree to the above policies of Huron Valley OBGYN.

**\*NAME AND DATE:**