Women's Integrated Health Care, P.C.

www.womensintegratedhealth.com

PATIENT INFORMATION

Today's Date:_______________

Last Name:__________________ M.I.:___ First Name: _____________________ DOB:____________

SS#: ________________ Age: ________ Marital Status: S__ M__ W__ D__ Other _____ Gender: F / M

Language: ________________ Race: White__ Black __ Other ___________ Ethnicity: ______________

Address: _____________________________ City: ____________ State: ____ Zip Code: ____________

Home Phone: _________________ Cell Phone: _________________ Work Phone: _________________

E-Mail: _____________________________ Pref. Method of Contact: 1st:___________ 2nd: _________

Do you consent to receive automated appointment reminders?: Y__ N__ Dr seeing today?: _____________

Primary Care Physician: _________________________ Primary Care Physician Phone: _____________

How did you hear about us? _______________________ Employer: _____________________________

Spouse's Name: _________________________________ Spouse's Home Phone: ___________________

Spouse's Cell Phone: ____________________________ Spouse's Employer: _____________________

INSURANCE

(please present card to the front desk so that we may make a copy of it to keep in our records. Please let us know if you have a secondary insurance)

*Primary: ____________________________ Subscriber Name: _________________________________

Relationship: _________________________ Subscriber's SS#: __________________________________

Subscriber's DOB: ____________________

*Secondary Insurance: __________________ Subscriber Name: _________________________________

***I authorize Women's Integrated Health Care to release any information or diagnosis of my condition to my insurance company for the purpose of payment for services rendered to me. I also authorize and request payment be made directly to Women's Integrated Health Care and understand that I am financially responsible for any balance due that is not a benefit by my insurance carrier or for any fees charged to me due to my failure to obtain referrals.**

___________________________________ _________________________ _______________

Signature of Responsible Party Relationship **Date**

EMERGENCY CONTACT

Emergency Contact: ____________________________ Phone Number: ____________________________

Relationship: ____________ Do you authorize this person access to your medical history? YES☐ NO☐

Second Contact: ________________________________ Phone Number: ____________________________

Relationship: ____________ Do you authorize this person access to your medical history? YES☐ NO☐

Do you have an Advanced Directive? YES☐ NO☐ Do you have an authorized Power of Attorney? YES☐ NO☐

WOMEN'S INTEGRATED HEALTH CARE, P.C.

Michelle M. Keeley, M.D. Martin W. Lapa, D.O. Stacey L. McEwen, D.O. Thomas C. Wright, D.O.
Cheryl K. Brophy, N.P. Nicole S. Peel, N.P.

OFFICE POLICIES

Normal Office Hours

Monday – Thursday

Appointments 8:30a.m. – 11:30 a.m.
1:00p.m. – 4:00 p.m.
Phones 9:00 a.m. – 12:00 p.m.
1:00 p.m. – 4:30 p.m.

Friday

Appointments 8:30 a.m. – 11:30 a.m.
Limited 1:00 p.m. – 4:00 p.m.
Phones 9:00 a.m. – 12:00 p.m.

Patient initials ______________

PATIENT INFORMATION
Upon checking in, please provide any new information you may have, such as; change of address, phone number, e-mail address, insurance card, etc. So that we have the most current information possible, we also ask that you update your patient information sheets annually.

Patient initials ______________

APPOINTMENTS
When scheduling an appointment, please be clear about the reason you wish to be seen. It is very important to distinguish the visit from a well visit, such as an annual gynecologic exam and a visit addressing a specific problem. Since some insurances require a referral from your primary care physician for problem visits, we are not able to combine a routine visit and a visit to address a problem; therefore, it may be necessary to schedule separate appointments if you have more than one health issue that needs to be addressed.

Patient initials ______________

SCHEDULED APPOINTMENTS
We understand that delays can happen, however; we must try to keep the other patients and doctors on time. If you know you will be late for your appointment, please let us know. We will do our best to accommodate you. If you are more than 15 minutes late, we will try to work you into the schedule, however, if there are no openings you will be asked to reschedule the appointment. **Please give 24 hours advance notice if you need to cancel. Appointments not canceled or rescheduled at least 24 hours ahead of time may be charged a fifty dollar ($50) fee. This fee will not be covered by your insurance company.** Patients who routinely no-show or cancel appointments may be discharged from the practice.

Patient initials ______________

SCHEDULED SURGERIES
Because large blocks of time are needed for surgery (whether in the office or in the hospital operating room), last minute cancellations can cause problems and added expenses for the office. **If a surgery is canceled without a medical reason within one week of the surgery date, you may be charged a seventy five dollar ($75) fee. This fee will not be covered by your insurance company.** We will not reschedule procedures if you have no-showed or canceled 3 times previously.

Patient initials ______________

CALLS WITH QUESTIONS
If you need to call the office with a question, please select the appropriate option for the call. If you are prompted to leave a message, please be sure to leave the information requested and we will return your call. Calls received in the morning are returned by the end of the morning and calls received in the afternoon are returned by the end of the day.

(Continued on back)

Patient initials

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PRESCRIPTION REFILLS
If you call for a prescription refill, please be sure to spell the name of the medication and give the dosage you are currently taking. Please provide the pharmacy name, location and telephone number to which you would like your prescription called. If you are calling for birth control refills and are due for an annual exam, your request may be denied unless you have an appointment already scheduled. Controlled substances will not be filled after hours or on weekends. Please do not wait until you are out of your medication to call for a refill.

PLEASE ALLOW 48 HOURS FOR PRESCRIPTION REFILLS

Patient initials

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AFTER HOURS
Should an urgent or emergent situation arise after office hours that cannot wait until the next business day, please call the main number (810) 606-9190 and stay on the line to be transferred to the answering service. The doctor on call will be contacted to return your call. Please note, prescription refills are not considered urgent. Should your call be deemed non-urgent, you may be charged a twenty five dollar ($25) telephone consultation fee. The fee will not be billed to your insurance company.

Patient initials

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HMO INSURANCE POLICIES
If you have an HMO insurance plan, there are certain appointment types for which you MUST have a referral from your primary care provider. If it is determined that the appointment you are scheduled for requires a referral we will make you aware of this and provide the necessary information in order for you to obtain authorization from your primary care doctor. It is your responsibility to obtain the referral and we must have it before you are seen. If we do not have it by the day prior to your appointment you will be asked to reschedule.

Patient initials

PAYMENT
FULL PAYMENT IS EXPECTED AT TIME OF SERVICE, including co-pays, otherwise, a $15 statement fee will be charged. If you receive a bill from our office, payment is due upon receipt. Should there be extenuating circumstances, you will need to speak with one of our billing managers by calling (810) 658-1480 or (810) 658-1046 immediately to make payment arrangements. Delinquent accounts (unpaid after 90 days) will be turned over to our collection agency, Russell Collections.

Patient initials

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YOUR HEALTH INSURANCE BENEFITS
Your health insurance policy is an agreement between you and your insurance company. Just as it is with other insurances that protect you, such as your homeowners or auto insurance. While we can assist you with providing the needed information (procedure and diagnosis codes), it is your responsibility to know services your policy covers and the amount of your deductibles and co-payments. It is also your responsibility to know which services, prescriptions, lab tests and treatments are covered under your specific health plan and which of those services require predetermination, prior-authorization or a referral in order to be paid.

UNDERSTANDING
My signature below indicates that I have read the policies above and that I understand them and I have been given a copy of this document. Any questions I may have had relating to the policies above have been answered and I understand and agree to follow these policies.

____
Print Name

____ ____________________
Patient or Parent/Guardian Signature Date

Revised 2/8/2022

PATIENT CENTERED MEDICAL NEIGHBORHOOD / HIPAA PRIVACY NOTICE

Our goal as your Specialist provider is to deliver efficient, high quality care. In order for us to achieve timely consultations and enhanced quality of care, we need to work closely with your Primary Care Physician (PCP) and other Specialists to coordinate your care.

Do you have a PCP? (please circle) Yes No

If yes, who is your PCP?

First and last name: ______________________________

Address: ______________________________

We would like to provide your PCP with any lab and/or test results performed in our office or ordered by our office.

May we provide these tests / labs to your PCP? (please circle) Yes No

If no, please explain why:

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I have been provided "Notice of Privacy Practices" (HIPAA) which, describes how my medical information may be disclosed and how I can get access to this information. **Initial** ________

I have read the provided information regarding my Medical Neighborhood and have been counseled on the importance of my continuity of care between me (the patient), my Primary Care Physician and any Specialist/s I may receive care from. **Initial** __________

Patient Signature: ______________________________ **Date:** ______________

Parent/Guardian Signature: ______________________ Date: ______________

Witness: ______________________________

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