Michigan Institute of OB/GYN and Brilliance Medical Spa

Patient Information Form

Please fill in all blanks completely with black ink

Date: ______________________

Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________

Home Phone: ______________________ Cell Phone: ______________________

Email Address: ______________________ Would you like email statements? Yes No

Providing your e-mail address will ensure you will receive important health news and special offers from our practice

Social Security Number: ______________________ Date of Birth: __________ Age: __________

Status: Single Married Widowed Divorced Separated

Patients Employer: ______________________ Occupation: ______________________

Employer's phone number: ______________________ Extension: __________

Insurance Holders Name: ______________________ Relationship: __________

Insurance Holders Social Security #: ______________________ Date of Birth __________

Employed By: ______________________ Phone Number: ______________________

Name of Insurance: ______________________

Contract #: ______________________ Group #: ______________________

Spouse's Name: ______________________

Primary Care Doctor: ______________________ Phone Number: ______________________

Emergency Contact Name and Phone Number: ______________________

How did you hear about us? (please be specific)

Friend/Family: ______________________ Doctor's Office: ______________________

Internet Search Engine: ______________________ Keywords used: ______________________

Facebook/Twitter: ______________________ Other: ______________________

Michigan Institute of OB/GYN,
& Joseph J. Prezzato MD, PLLC
Office Policies

I agree to the release of medical and other information to my insurance company for review of my coverage and/or for the processing of claims for services rendered to me.

I permit a copy of this authorization to be used in place of the original.

All HMO's require a written referral or prior authorization for certain visits. This is your responsibility. If you do not have this authorization or referral, your appointment may have to be rescheduled or you will have to contact your primary care physician for approval of services prior to seeing our doctor.

AUTHORIZATIONS TO PAY BENEFITS TO PROVIDER: I represent that I have insurance coverage and do hereby authorize my carrier to pay and assign directly to Michigan Institute of OB/GYN all benefits otherwise payable to me for the service described. I understand that I am accepting responsibility for any part and all of the charges for services provided if my insurance company(ies) do(es) not reimburse the physicians or myself, including but not limited to, co-pays and deductibles. If payment is sent directly to me, I will promptly submit the same to Michigan Institute of OB/GYN.

An advanced directive is a document that states how you want medical decisions made if you lose the ability to make them for yourself. There are two types of advance directives: Durable Power of Attorney for Health Care and living wills. If you have an Advance directive please provide our office with that information.

Insurance Waiver:
Knowing your insurance is between you and your insurance company. The physicians and staff of Michigan Institute of OB/GYN and Joseph J. Prezzato MD, PLLC are not responsible for knowing your benefits.
By signing this waiver, you agree to pay for any uncovered services.

I understand that certain medical insurance carriers (Medicare, BCBS of Michigan, and other commercial carriers) are likely to deny payment for certain tests and annual physical exams because they usually do not pay for routine screening or have guidelines on how often they can be performed. If my medical insurance carrier denies payment, I agree to be personally and fully responsible for payment.

Your insurance policy is a contract between you and your insurance company and is your responsibility to understand your individual coverage. Failure to understand your coverage may result in you (the patient/guarantor) being responsible for your medical bills. Michigan Institute of OB/GYN and/or Joseph J. Prezzato, MD PLLC will bill your insurance company for you with the information that you provide. Lack of accurate information may result in your being responsible for payment. If the insurance claim remains unpaid beyond 60 days, we will bill you as a self-pay account. It will then be your responsibility to pay us and then contact your insurance company to settle the claim with you.

If we are contracted with your insurance company you will generally be responsible for office visit co-pays, coinsurance and/or deductibles as applicable. You may be asked to pay for services prior to them being

rendered if your plan has a deductible. Office visit co-pays are collected at the time of service. An additional $10.00 late fee will be assessed if you choose to not pay at the time of service. We will also collect all patient balances each visit. Patients will not be able to be seen unless all balances have been paid. We currently participate with most major health insurance carriers. If you have commercial insurance that we do not have a contract with, you will be responsible for all charges incurred that are not covered by your insurance company, If you are unable to meet your payment obligations due to financial hardship, you may contact our billing department to discuss setting up a payment plan.

If you have HMO insurance policy, it is your responsibility to obtain a referral prior to your visit. If you do not have a valid referral for your appointment you will need to reschedule your appointment. Otherwise we will expect payment at the time of service.

If your account goes to collection or if your check has been rejected by the bank, you will be responsible for the original balance of your account along with all bank or collection fees as well as a $25.00 clerical fee. Collections fees are typically around 30%.

If you have suffered an injury, your insurance company may send you a questionnaire regarding the nature of your injury. Until this form is completed and returned they will not pay your claims and you will then be personally responsible for payment. Please return this form to your insurance company immediately. If you have any questions regarding the form, please contact your insurance company.

A fee of $10.00 per form is charged for all disability/workers compensation forms that you present to us. This fee is to be paid by the patient. Forms will be completed within seven business days and will not be released until payment is made.

If you require a note regarding work or school restrictions you must discuss this with the doctor at the time of your visit. Notes will not be backdated for any reason.

Prescription requests approved by the doctor will be transmitted to your pharmacy within two business days. Refill requests for controlled substances will not be authorized after normal office hours.

Health Information that we provide to outside parties other than your insurance company or physician's office (whether verbal or written) requires written consent from the patient. A release of Information Form is available.

No Show: All appointments must be cancelled 24 hours prior if you cannot make it for your appointment time. A $50.00 no-show fee may be charged for failure to comply with this request. If you have two no-show appointments you *may* no longer be accepted as a patient in our practice.

I have read and understand the above information.

____

Patient Printed Name

____ __________________________

Patient Signature (or patient's legal representative) Date Signed

Michigan Institute of OB/GYN
Consent to Use Protected Health Information
For Treatment, Payment and Health Care Operations

I consent to allow Michigan Institute of OB/GYN, and Joseph J. Prezzato MD, PLLC to use or disclose my protected health information for treatment, payment and health care operations.

> Treatment means the provision, coordination, or management of health care and related services by one or more health care providers.
>
> Payment means the activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care.
>
> Health care operations means conducting quality assessment and improvement activities; reviewing the competence or qualifications of health care professionals; underwriting, premium rating, and other activities related to health insurance contracts; medical reviews; legal services; auditing functions; and business management and general administrative activities of Michigan Institute of OB/GYN, and Joseph J. Prezzato MD, PLLC.

I consent to allow Michigan Institute of OB/GYN, and Joseph J. Prezzato MD, PLLC to disclose my protected health information for treatment activities of another health care provider.

I consent to allow Michigan Institute of OB/GYN, and Joseph J. Prezzato MD, PLLC to disclose my protected health information to another covered entity or to another health care provider for the payment activities of the entity that receives the information.

I consent to allow Michigan Institute of OB/GYN, and Joseph J. Prezzato MD, PLLC to disclose protected health information to another covered entity for health care operations activities, provided that Michigan Institute of OB/GYN, and Joseph J. Prezzato MD, PLLC and the other covered entity has or had a relationship with the below named patient. The disclosure must be for treatment, payment, or health care operations or for the purpose of health care fraud and abuse detection or compliance.

____

Patient Printed Name

____ ___________________________

Signature of Person Authorizing Consent Date Signed

____

Relationship to patient

Michigan Institute of OB/GYN, and Joseph J. Prezzato MD, PLLC

Acknowledgement of Notice Form

Acknowledgement of Receipt of Notice and Privacy Practices

(If this is your first time completing this form only complete the highlighted section)

I, ________________________________, have received a copy of Michigan Institute of OB/GYN, and Joseph J. Prezzato MD, PLLC, Notice of Privacy Practices.

____ __________________

Signature of Patient Date

I, ________________________________, have received a copy of Michigan Institute of OB/GYN, and Joseph J. Prezzato MD, PLLC, Notice of Privacy Practices.

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