OAKLAND MACOMB

Welcome and thank you for choosing our office. Your medical care is very important to us.
Please feel free to contact our office by phone or visit our website.

www.oaklandmacombobgyn.com

Patient Information

_____ _____ _____ _____/_____/_____ _____
Last Name First Name MI Date of Birth Marital Status

_____ _____ _____ _____
Address City State Zip

(____)_____ (____)_____ (____)_____
Cell Phone Number Home Phone Number Work Number

Please indicate your primary number: CELL HOME WORK (Circle One)

E-Mail Address_____ Social Security #_____-_____-_____

Emergency Contact:_____ _____ (____)_____-_____
Name Relation Phone Number

Primary Insurance Information

_____ _____
Name of Responsible Party's Employer Name of Insurance

_____/_____ _____ _____ _____
Name of Subscriber Subscriber DOB Group # Contract # Date Effective

I authorize payment of insurance benefits to Oakland Macomb Obstetrics and Gynecology, P.C. I agree that I shall be legally responsible for any medical or surgical charge incurred in the course of my treatment, including those that are rejected as co-pay, deductible, or unpaid service, in excess of any hospitalization or health insurance that might be applicable.

Release of Information

I authorize Oakland Macomb Obstetrics and Gynecology, P.C. to release any medical information required by my health insurance company to process a claim/claims.

Consent to Testing

In connection with certain diagnostic tests, I understand that specimens of blood and urine and other bodily fluids, tissues or products may be obtained and that tests will be performed upon such fluids, tissue and products, and I consent to this. I understand that if it becomes necessary that I be tested for antibodies to Human Immunodeficiency Virus (HIV, the virus that causes AIDS), I will be counseled by my physician and I will be given the choice of consenting in writing to such testing. I have been informed that my written consent to testing for HIV antibody or other communicable diseases is not required by law in situations where a health care provider sustains an exposure to my blood or bodily fluids.

_____ _____ _____ _____
Signature of Patient or Legally Authorized Representative Date Witness Date

I voluntarily consent to receive all such medical treatment that my physician considers beneficial to me. I understand that this care may include diagnostic tests, examinations, medical or surgical treatment. I am aware that the practice of medicine is not an exact science, and I hereby acknowledge that no guarantees have been made to me as to the results or treatment and examinations provided.

You have the right to an Advance Directive (Durable Power of Attorney for Health care). Please check if you have the following:
☐ Durable Power of Attorney for Health Care ☐ I don't have either, but would like more information ☐ I don't need that information

Patient Signature _____ Date_____

Witness _____ Date_____

PLEASE TURN OVER. THANK YOU.

Oakland Macomb Obstetrics & Gynecology, P.C.
Acknowledgement of Receipt of Notice of Privacy Information Practices

My signature on this form indicates that I have **received** a Notice of Privacy Information Practices.

In the event that I have questions, I have been given the name of the Privacy Officer, whose information is listed below, and who will be able to answer my questions.

Privacy Officer
John Micallef
1701 South Boulevard East, Suite 200
Rochester Hills, MI 48307
(248) 997 - 5805

I request the following person(s) to receive information regarding my protected health information:

Name _____ Relation _____ Birth Date _____

Name _____ Relation _____ Birth Date _____

You as a patient have the right to:

1. Inspect and copy your medical information that may be used to make decisions about your care.

2. Request an amendment to your medical record if you feel they are incorrect or incomplete. The physician may deny my request and notify me of the reason for her/his denial.

3. Request an accounting of disclosures. This is a list of disclosure for other than treatment, payment or health care operations.

4. Request a restriction or limitation on the medical information used or disclosed about me for treatment, payment or health care operations. All requests must be made in writing. However, the physician has the right to deny the restriction. If she/he does agree to the restriction, the office will comply with your request unless the information is needed to provide you with emergency care.

Print Patient Name _____

Signature _____ Date_____

Office use only:

____ Patient refused to sign consent, despite a good faith effort to receive acknowledgment.

Employee Signature _____ **Date** _____

*Patient Signature*_____ Date_____