PATIENT INFORMATION

NAME:_____

DATE OF BIRTH:_____ AGE:_____ LAST 4 DIGITS OF S.S. NUMBER:_____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

STREET ADDRESS:_____

CITY :_____ STATE:_____ ZIP CODE:_____ BEST PHONE:_____

EMAIL:_____ ALT PHONE:_____

LIST NAMES OF INDIVIDUALS WHOM YOU APPROVE WE CAN DISCUSS ALL SENSITIVE TEST RESULTS WITH_____

IS IT OK TO LEAVE TEST RESULTINFORMATION OVER VOICEMAIL? _____(YES/NO)

IS IT OK TO EMAIL YOU WITH TES RESULT INFORMATION?_____(YES/NO)

EMPLOYER:_____ WORK PHONE:_____

EMERGENCY CONTACT NAME:_____ REALTIONSHIP:_____PHONE:_____

RELIGIOUS PREFERENCE:_____ PREFFERED LANGUAGE:_____

RACE:_____

PREFERRED PHARMACY:

PHARMACY NAME:_____ PHONE NUMBER:_____

CITY/STATE:_____

PRIMARY / REFERRING PHYSICIAN:

NAME:_____M.D/D.O. PHONE: _____

STREET ADDRESS:_____ CITY/STATE/ZIP:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE_____

IF THE SUBSCRIBER IS NOT THE PATIENT:

NAME/RELATIONSHIP:_____LAST 4 DIGITS OF S.S. NUMBER:_____
DATE OF BIRTH:_____ EMPLOYER:_____

SECONDARY INSURANCE: _____
IF THE SUBSCRIBER IS NOT THE PATIENT:
NAME/RELATIONSHIP:_____LAST 4 DIGITS OF S.S. NUMBER:_____
DATE OF BIRTH:_____ EMPLOYER:_____

GUARANTOR(IF PATIENT IS A MINOR):

NAME:_____ RELATIONSHIP:_____

OBSTETRICS & GYNECOLOGY ASSOCIATES

OUTPATIENT GENERAL CONSENT FORM

PATIENT'S NAME _____

1. **CONSENT**: I consent to routine medical, nursing care including procedures, examinations, tests, immunizations, regional and local anesthesia, series of treatments/procedures and other treatment by (Dr.) _____ and his/her assistants, associates, or consultants as is necessary in their judgment. I realize that _____ is a teaching facility affiliated with various universities including but not limited to Wayne State University and Michigan State University, Oakland University, and consent to medical care being performed by students, residents, physician extenders or medical support staff who are supervised by experienced doctors and nurses. I know if I have any questions about my care or tests, I should be sure to ask the doctors/nurses/staff about them. I know it is up to me to tell the doctors/nurses/staff about any health problems or allergies I have. I must also tell the doctors/nurses/staff about drugs or medications that I am taking. I consent to the testing and disposal of specimens of my blood, urine, and other bodily fluids, tissues and products. I consent to HIV testing having received verbal explanation and education materials regarding HIV testing; I understand that an HIV (human-immunodeficiency virus) and/or a HBV (hepatitis B virus) or HCV (hepatitis C virus) test may be done upon me without my further consent if a doctor, health professional or employee sustains percutaneous, mucous membrane or open wound exposure to my blood or other bodily fluid.
2. **ADDITIONAL CONSENT FORMS**: I understand that for certain procedures deemed necessary by my physician(s), I will be required to sign a special consent form. Further, if I do not fully understand a procedure or its risks, consequences and alternative methods of treatment, I have the right to question the appropriate health care professionals.
3. **RELEASE OF INFORMATION**: Obstetrics & Gynecology Associates releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practices.
4. **INSURANCE**: I authorize the doctor and the staff to review my insurance coverage with my insurance company. I authorize payment of my insurance benefits to be made directly to the doctor. I agree to pay in full any and all charges not covered by insurance or other benefits. I understand that providers may bill separately.
5. **NO GUARANTEES**: I understand that the practice of medicine is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the doctors or assistants. I understand that no contract, warranty, guarantee, or promise concerning the results of medical service is made. This consent to treatment form is not a contract, nor is it an offer to contract, nor is it an acceptance of an offer to contract.
6. **PERSONAL PROPERTY**: I understand and agree the Obstetrics & Gynecology Associates shall not be liable for the loss or damage of any personal property which may or may not be given to Obstetrics & Gynecology Associates staff during my stay.
7. **NOTICE OF PRIVACY PRACTICE**: I have received a copy of Obstetrics & Gynecology Associates Notice of Privacy Practices. I understand that additional copies of the notice will be provided to me upon my request.

I CERTIFY THAT ANY AND ALL INFORMATION PROVIDED BY ME IN FURTHERANCE OF MY APPLICATION FOR HEALTH CARE BENEFITS ARE TRUE. I HAVE READ THIS FORM. IT HAS BEEN FULLY EXPLAINED TO ME, AND ALL OF MY QUESTIONS ABOUT THE FORM HAVE BEEN ANSWERED. I UNDERSTAND ITS CONSENTS.

_____ _____ _____ _____

Patient Signature Date Patient's Personal Representative's Signature Date

_____ _____

Witness Date Representative's Authority To Act/Relationship to Patient

OBSTETRICS & GYNECOLOGY ASSOCIATES

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name_____Date of Birth __/__/____
Social Security #___-___-____ Maiden/Other Name_____
Patient Address_____Street City State Zip
Phone Number: _____

I authorize

to release information contained in my medical record (including if applicable, information about HIV infection or AIDS,information about substance abuse treatment and information about mental health services).

Name to whom informaiton may be released- Obstetrics & Gynecology Associates

25150 Ford Road, Suite 200. Dearborn Heights MI 48127

16815 E iefferson Avenue, Grosse Pointe, MI 48230

Phone Number 313 277 0400
Fax Number (313) 277 0300

Specific type of information to be disclosed :(Circle)

Discharge Summary	Pathology Reports	Emergency Department Report
History & Physical	Radiology Reports	Prenatal Records/Delivery Records
Consultations	Radiology Images/CD	
Laboratory Results	Operative Report	Other(Specify): _____

The Purpose and Need for Such Disclosure: Continuity of Care

For mental health records, or records pertaining to HIV Infections or AIDS, the above paragraph must include a statement as to how the information to be disclosed is relevant to the purpose and need for such disclosure. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. Your protected health information will be disclosed as specified in this authorization. This authorization will expire with written request. This information could be subject to re-disclosure by the recipient and may then no longer be protected.

_____ __/__/__
Signature of Patient/Parent/Personal Representative Date

If you are signing as a: (parent, guardian, or personal representative) circle this relationship and sign this form below.

Relationship to Patient
Print Name