advanced women's health specialists

43138 Dequindre Road, Sterling Hts, MI 48314
Phone: (586) 262-5060 Fax: (586) 262-5061

## WELCOME LETTER

Dear Patient,

Welcome to Advanced Women's Health Specialists, PLLC. Enclosed is our welcome packet as well as a few pertinent details of our office. Please download and fill out the necessary paperwork prior to arriving at your scheduled appointment. Then, you can bring it with you to your appointment. If you are unable to do this, please arrive at least 30 minutes prior to your scheduled appointment to complete all necessary paperwork.

If you are being referred to us by a physician for a preexisting condition, please have your pertinent medical records faxed to our office prior to your scheduled visit.

It will be your responsibility to check with your insurance company to see if authorization is required. Please bring your insurance card to your visit so we can make a copy and keep it for our records.

Your appointment time will be set aside so you have adequate time to discuss your care with the provider. Please note that this is valuable time allocated to your interest. If you are unable to make it to your appointment and need to reschedule for any reason, please notify the office at least 24 hours prior to your scheduled time, to avoid our $50 no show fee. We hope to provide you with the best service and care possible and will do our best to accommodate your requests.

Thank you again for choosing Advanced Women's Health Specialists, PLLC. We look forward to your visit.

Sincerely,

Jasmin Ghuznavi, MD
Kulsoom Jafri, MD
Heather Powers, FNP

## PATIENT INFORMATION

Last Name _____ First _____
Middle _____
Address _____
City _____ Zip _____
Home Phone (___) _____ Work (___) _____
cell (___) _____ I prefer _____
Age _____ Date of Birth ____/____/____
Social Security# _____ Driver's License # _____
Marital Status: _____ Married _____ Single _____ Widow(er) _____ Divorced _____
Full Time Student: _____Yes _____No Employed BY _____
Employer's Phone # _____
Employer's Address _____ City _____ Zip _____
Name of Spouse (If applicable) _____ Date of Birth _____
Spouse's Employer _____
Employers Phone# _____
Employer's Address: _____ City _____ Zip _____
Nearest Relative/Friend (Not Living with You) _____
Phone # _____

## INSURANCE INFORMATION:

Primary Insurance Company Name: _____
Phone # (___) _____
Policy Holder's Name _____ Date of Birth _____
Group _____ ID# _____
Patient's Relationship to the Policy Holder? _____ Self _____ Spouse _____ Child
Secondary Insurance Name: _____ Phone # (___) _____
Policy Holder's Name _____ Date of Birth _____
Group # _____ ID# _____
Patient's Relationship to the Policy Holder? _____ Self _____ Spouse _____ Child

## REFERRAL:

Whom May We Thank for Your Referral?

- NEWSPAPER _____
- WEBSITE _____
- FRIEND/FAMILY _____
- PRIMARY CARE PHYSICIAN _____
- OTHER _____

## AUTHORIZATIONS:

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and plans for future care and treatment. The health records will be retained by AWHS even if my healthcare provider(s) leave the practice. I authorize the release of any medical information necessary to process insurance claims and request payment of benefits either to myself or the party who accepts assignment / participates.

**Signature of Patient / Legal Guardian:** _____ **Date:** _____

# TELEPHONE AUTHORIZATION FORM

Patient Name: _____

Email Address: _____

Pharmacy name, location, and phone: _____

_____

Please tell us the telephone number we may use to contact you for appointment reminders, test results, return phone calls, text messages, and voice mails.

_____ ( ) Cell Phone ( ) Other _____ You agree to receive text messages

_____ ( ) Cell Phone ( ) Other _____ For office communications? ( ) **YES**

( ) **NO**

Please indicate with whom we may speak with or leave a message with regarding your private health information and test results if you are unavailable at the above numbers.

_____

Name Phone Number

Please indicate with whom you do **NOT** want us to speak with or leave a message with regarding your private health information.

_____

Name

_____

Patient Signature Date

## Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

• **Right to receive a copy of this Notice of Privacy Practices**—We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

• **Right to authorize other use and disclosure**—This means you have the right to authorize or deny any other use or disclosure of protected health information that is not specified within this notice. You may revoke an authorization, at any time, in writing, except to the extent that your Healthcare Provider or our office has taken an action in reliance on the use or disclosure indicated in the authorization.
• **Right to designate a personal representative**—This means you may designate one person with the delegated authority to consent to or authorize the use or disclosure of protected health information.
• **Right to inspect and copy**—This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record. We have the right to charge a reasonable fee for copies as established by professional, state, or federal guidelines. A time can be scheduled for a member of our staff to sit down with you and inspect your records.
• **Right to request a restriction**—This means you may ask us, in writing, not to use or disclose any part of your protected health information
for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases, we may deny your request for a restriction.
• **Right to request an amendment**—This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.
• **Right to an accountability of disclosures**—This means that you may request a listing of disclosures that we have made, of your protected health information, to entities or persons outside of our office other than for the purposes of treatment, payment, healthcare operations, or a purpose authorized by you.

## Complaints

You may file a complaint with us by notifying our HIPAA Committee at 517/484-3000, extension 112. Complaints must be filed within 180 days of the occurrence. Other complaints may be sent to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

_____ _____

Patient Signature Date

# General consent to treat

I request and authorize medical and surgical treatment as may be deemed necessary and appropriate by the physician and his/her designees participating in my care.

This care may include diagnostic, radiologic, and laboratory procedures, anesthesia, Therapeutic procedures, drugs, ultrasound, nursing, and emergency care, and any other testing medically necessary for the diagnosis and care of the patient.

Patient's signature_____ Date_____

Witness signature_____ Date_____

## e-PRESCRIBING PBM CONSENT FORM

Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions**— Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions**—Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Advanced Women's Health Specialists can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Patient Name (printed) _____ Date of Birth ___ /___ /____

Signature of patient (or representative) _____

Date ___ /___ /_____ Relationship if other than patient_____

Consent Denied _____ Date ___ /___ /_____

# FINANCIAL POLICY

Dear Patient:

It is our hope that we can provide our patients with the best care and service possible. Therefore, it is important that you have a complete understanding of our financial policy as it relates to your financial obligation. Please read the following document thoroughly and sign below only after you have read and agree to comply with the policy of Advanced Women's Health Specialists.

- If you are a member of a health plan that Advanced Women's Health Specialists participates with, we will submit your claim on your behalf. Your co-payment will be expected at the time services are rendered. You will also be responsible for any services provided that your health care plan deems as "not covered" or "not a benefit".

- If we do not participate with your insurance plan, full payment is due at the time services are rendered.

- Medicare patients will be responsible for their deductible, co-insurance and any services Medicare may deem "medically" unnecessary.

- If you are a minor, the parent or guardian accompanying you to the visit will be held responsible for the payment.

- We reserve the right to charge for additional services that may be rendered on your behalf to better assist you, such as phone consultations, copying of medical records and completion of relevant forms. We ask that you provide us with a week's notice for the above-mentioned requests. There is a minimum $25 fee for each set of copies that is requested and a $25 fee for each form that needs to be filled out by the physician.

- We accept the following forms of payment: Cash, Check, MasterCard and Visa Debit and Credit Cards, and Discover. Please note that there will be a $35 fee for any check that is returned due to insufficient funds.

- We reserve the right to turn your account over to collections if it is deemed that you have defaulted on payments despite written and phone notifications. If payment is late, a $10 charge will be added to your account for each additional month of delayed payment. You will also incur a $35 non-refundable fee once your account has been sent to collections. You agree to pay all collection fees, including any relevant legal and attorney fees incurred by Advanced Women's Health Specialists, PLLC, in enforcing this policy.

- We value your appointment and we believe that as a courtesy to patients like yourself, any plan to cancel or reschedule an appointment must be performed 24 hours in advance. Failure to do so may result in a charge of $50.

Patient Signature: _____ Date: _____

# Laboratory waiver

Patient name: _____

I understand that certain medical insurances may deny payment for laboratory testing, immunizations, contraceptive techniques, pap smears, and routine physical exams. I understand that if my insurance carrier denies coverage regarding any of the procedures performed at AWHS, PLLC, I personally agree to fulfill the payment for which I am responsible.

_____ _____

Patient signature Date

_____ _____

Witness signature Date

## OB Financial Policies

Thank you for choosing Advanced Women's Health Specialists for your pregnancy and delivery. In an effort to keep your healthcare costs to a minimum, we have adopted the following policies. Your understanding of these policies is important. Please review this document and contact our billing office with any questions you may have.

### Global Care

Your insurance company describes this as all prenatal visits relating to your pregnancy from the second visit until delivery. Therefore, Advanced Women's Health Specialists (AWHS) will bill your prenatal visits (13-14 visits), delivery and postpartum visits separately.

**Labs and ultrasounds are not considered to be part of the global fee and are billed separately at time of service.** Depending on your insurance coverage, you may be responsible for a portion of these charges.

### Patient Portion and OB Payment Plan

After your initial visit, we recommend contacting your insurance company to obtain benefits for pregnancy and verify any precertification of services required. Some insurance requires the patient to contact them for prenatal registration.

**OB Payment Plan** - When calling for pregnancy benefits, your insurance will advise you of your portion of the global fee. This is called your co-insurance. We are authorized by your insurance to collect this portion prior to delivery. Our policy is that the amount due be collected by the 32nd week of pregnancy. We will create an OB Payment Plan that will be available by your second OB visit. We offer these options in regard to payment:

- Payment in full (due at your third visit)
- Monthly payments at time of visit, up to 32 weeks

**Please remember that you may have a deductible that will have to be met. If this is the case; you may have additional charges that will be your responsibility. Deductibles can't be collected upfront. The claims must go through the insurance first. ****

### Co pays

Most insurances do not charge a copay per visit AFTER your initial visit. They do, however, charge copays for any testing or visit outside of the "Routine Prenatal Care". Specialized testing, such as non-stress testing, may require copays. Copays are due at time of service. A late fee of $25.00 will be assessed to those not paid at time of service.

## HRA/HAS/Flex Spending

Higher deductible plans (HRA, HSA, and FLEX) encourage patients to share more responsibility for how their health care dollars are spent. This means that you will have a larger portion of your health care costs to pay. Plans vary from insurance to insurance making it almost impossible to track all plans. Due to this, AWHS requires the global fee to be paid by the 32nd week of pregnancy, as with traditional plans.

## Changes in Insurance

Should you have a change in insurance during your pregnancy, please contact the billing department as soon as you have all of the new information. We recommend contacting your insurance company to obtain benefits for pregnancy and verify any precertification of services required.

****A note about benefits****

Please keep in mind that although your insurance quotes benefits in regard to pregnancy, there is no guarantee of payment. Insurances consider many factors when claims are being adjudicated or processed. Any questions in regards to an insurance payment must be directed to your insurance company.

## Leaving the Practice

Should it be necessary for you to transfer care during your pregnancy, AWHS will bill your insurance for their portion of the global fee.

## Tubal Litigation (sterilization) at Delivery

Sterilization procedures are an additional charge. Should you decide to proceed with sterilization, we recommend contacting your insurance company in regard to sterilization benefits. You will be responsible for any co-insurance amounts prior to your delivery.

I acknowledge that I am signing this statement voluntarily, and that it is not being signed under duress or after the services have already been provided.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

natera | **Empower™** Hereditary cancer test

| TODAY'S DATE: | NAME: | AGE: | DATE OF BIRTH: |
|---|---|---|---|
| | | | |

## Is there cancer in your family? Learn if hereditary cancer testing is right for you. For more information text EMPOWER to 636363

Is there a history of any of the following in you or your family? **Please check all that apply.** (Relatives include your parents, brothers/sisters, children, uncles, aunts, grandparents, grandchildren, nieces, nephews, or half-siblings)

**Pancreatic Cancer**
- ☐ Pancreatic cancer (any age)

**Ovarian Cancer**
- ☐ Ovarian cancer (any age)

**Uterine Cancer**
- ☐ Uterine cancer under age 50

**Breast Cancer**
- ☐ At age 50 or younger
- ☐ 2 or more breast cancers in the same person (at any ages)
- ☐ Male breast cancer (any age)
- ☐ Personal history of breast cancer (any age)

If yes, was it:
- ☐ Triple Negative ☐ Metastatic

**Colon/Rectal Cancer**
- ☐ Personal history of colon/rectal cancer (any age)
- ☐ Relative with colon/rectal cancer under age 50
- ☐ 10 or more colon polyps: Number of polyps _____

**Prostate Cancer**
- ☐ Metastatic (stage 4 or advanced) prostate cancer
- ☐ Personal history of prostate cancer: Gleason Score _____

- ☐ **3 family members at any age with the following cancers on the same side of the family:** breast and/or prostate, uterine/endometrial and/or colorectal
- ☐ **Ashkenazi Jewish ancestry**
- ☐ **Unknown or limited family history (adopted or less than 2 female relatives living past age 45). Please Explain:** _____
- ☐ **Known hereditary cancer gene mutation in the family. Please list gene if known:** _____
- ☐ **Other cancers not listed above**

**Checked any of the boxes? If yes, please fill out the next section. Hereditary cancer testing can help you understand if you or your relatives have an increased risk for developing cancer, and help guide your medical care.**

| Cancer site | Person (yourself or blood relative's relationship to you) | Approximate age at diagnosis | Side of the family | | Relative deceased? |
|---|---|---|---|---|---|
| | | | Mother's | Father's | |
| Example: Breast Cancer | Aunt | 42 | X | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ |

**Please check the box if any above relative is willing to be tested** ☐

## Breast cancer risk assessment tool. Your answers may determine if you are eligible for enhanced breast screening:

1. Height ____ft ____in 2. Weight _____ lbs 3. Have you had children? ☐ Yes ☐ No How old were you when you had your first child? _____

4. Approximate age at first menstrual period? _____ 5. Have you gone through menopause? ☐ Yes ☐ No ☐ Ongoing If yes, at approximately what age? _____

6. Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

7. Have you ever used hormone replacement therapy? ☐ Yes ☐ No ☐ Ongoing Start date: _____
If yes, what type? ☐ Estrogen ☐ Estrogen+Progesterone ☐ I don't know End date: _____

8. Number of relatives: Sisters: _____ Daughters: _____ Maternal aunts: _____ Paternal aunts: _____ Maternal half-sisters: _____ Paternal half-sisters: _____

9. Have you ever had a breast biopsy? ☐ Yes ☐ No If yes, what was the result? ☐ Hyperplasia (no atypia) ☐ Atypical hyperplasia ☐ LCIS ☐ I don't know

10. Have you had your breast density assessed by mammogram? ☐ Yes ☐ No ☐ Unknown

**If know, complete ONE of the following:** ☐ **VAS percentage density** ____-____ % ☐ **Volpara volumetric density** ____-____%

☐ **BI-RADS ATLAS density:** ☐ Fatty ☐ Average ☐ Heterogeneously dense ☐ Extremely dense ☐ Unknown

## Signatures

| Patient Name | Patient Signature | Date |
|---|---|---|
| | | |
| **Provider Name** | **Provider Signature** | **Date** |

## For Office Use Only

**Patient offered hereditary cancer genetic testing** (check all that apply)

☐ **Yes** ☐ **No** ☐ **Patient accepted** ☐ **Patient declined**

**Patient previously tested** ☐ **Yes** ☐ **No**

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## CONSENT TO SUBSTITUTE OBSTETRICIAN AND GYNECOLOGICAL CARE AT TIME OF DELIVERY OR AN EMERGENCY

Patient Name: _____ Date: _____

Patient's Date of Birth: _____

In engaging you as my obstetrician and/or gynecologist, I understand that if you are unavailable or unable for any reason to be present and to deliver me or attend to a medical emergency at the time of my confinement, you will exercise reasonable care and diligence in referring me to another duly licensed physician to render obstetrical and/or gynecological care to me at that time. I agree to hold you free from any responsibility in connection with any services that may be performed by any physician to whom you may refer me or who is called in your absence.

ALTERNATING PHYSICIANS WHO MAY ROTATE COVERAGE ARE AS FOLLOWS:

Jasmin Ghuznavi, M.D. – Kulsoom Jafri, M.D.
Paint Creek OB/GYN: Carole Condevaux, M.D. – Anupa Vansadia, M.D. – Emma Gaboury, M.D. – Kayla Busuito, D.O.
Eastside Gynecology & Obstetrics: Ashley Zeilenga, D.O.
**Hospital Laborist (includes both male and female providers)**

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

I hereby certify that, in my opinion, the patient's consent is an informed consent.

Signature of Physician: _____ Date: _____

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Jasmin Ghuznavi, MD, FACOG  Kulsoom Jafri, MD  Heather Powers, FNP

Name:_____ Date of Birth:_____ Today's Date:_____

**Medical History (any new from last visit):**

| | | |
|---|---|---|
| ☐Asthma | ☐ Depression/Mental Illness | ☐Diabetes: **Type I** |
| ☐Arthritis | ☐High Blood Pressure | ☐Diabetes: **Type II** |
| ☐ Heart Murmur | ☐HIV | ☐Polycycstic Ovaries (PCOS) |
| ☐ Heart Disease | ☐Kidney Disease | ☐Endometriosis |
| ☐Stroke | ☐Osteoporosis | ☐Uterine Fibroids |
| ☐Epilepsy | ☐Cholesterol | ☐Cancer (Please specify type) |
| ☐Migraines | ☐Thyroid Disease: **Hyperthyroid** | ☐_____ |
| ☐Lupus | ☐Thyroid Disease: **Hypothyroid** | ☐Other: |
| ☐Emphysema | ☐Ovarian Cysts | ☐_____ |

**Social History:** (please circle): Single Married Divorced Widowed Female Partner Male Partner

Occupation:_____ Student: Yes No

Do you use tobacco? Yes No Previously How many packs/cigarettes per day?_____
Do you use alcohol? Yes No Previously How many drinks per day/week?_____
Do you use drugs? Yes No Previously What kind?_____ How Often?_____

**OB/GYN History:**

First Day of your last period:_____
Age of first period:____ How long do your periods last?_____ How many days between periods?_____
Cramping during periods? Yes No Flow: Heavy Medium Light Clots? Yes No
Are you sexually active? Yes No Never
Current sexual partner(s)? Male Female Both
Do you have a history of sexually transmitted diseases? Yes No Please specify type:_____
What do you use for contraception?_____
What have you previously used? IUD Pills Condoms Patch NuvaRing Other:_____
Date of last pap smear:_____ Normal Abnormal Date of last mammogram:_____ Normal Abnormal
Date of last colonoscopy:_____ Normal Abnormal Date of last bone density:_____ Normal Abnormal
How many times have you been pregnant?_____ Number of children:_____

| Date of Delivery | Weeks at Delivery | C-Section/Vaginal | Male/Female | Baby's birth weight | Complications |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Name: _____

**Surgical History (any new from last visit):**

| Date | Type of surgery | Date | Type of surgery |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**Medication (please include vitamins and over the counter medications):**

| Medication | Dosage (mg, IU) | How often do you take it |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Allergies (please include medications, environmental, and food allergies):**

| Allergy | Reaction | Allergy | Reaction |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**Family Medical History (please include relationship to you – parents, siblings, grandparents):**

☐ Diabetes: **Type I**_____ ☐ Osteoporosis _____ ☐ Ovarian Cancer _____
☐ Diabetes: **Type II**_____ ☐ Stroke _____ ☐ Other Cancer (please specify)
☐ High Blood Pressure _____ ☐ Lupus _____ _____
☐ Depression/Mental Illness _____ ☐ Heart Disease _____ _____
☐ Thyroid Disease: **Hypothyroid** _____ ☐ Emphysema _____ ☐ Other (please specify)
☐ Thyroid Disease: **Hyperthyroid** _____ ☐ Breast Cancer _____ _____
☐ Kidney Disease _____ ☐ Colon Cancer _____ _____

**Review of Symptoms (please include any symptoms or problems you are experiencing today):**

Concerns of problems you would like to discuss today: _____

☐ Tired/Fatigue
☐ Loss of Appetite
☐ Bleeding of Gums
☐ Headache
☐ Chest Pain
☐ Shortness of Breath
☐ Shortness of Breath with Exercise
☐ Nausea
☐ Frequent Urination at Night
☐ Urinary Frequency
☐ Urinary Urgency
☐ Blood in Urine
☐ Joint Pain
☐ Loss of Hair
☐ Memory/Concentration Difficulty
☐ Decreased Libido (sex drive)
☐ Ringing in Ears
☐ Vomiting
☐ Blood in Stool
☐ Intolerance to Cold
☐ Intolerance to heat
☐ Night Sweats
☐ Decreased Hearing
☐ Diarrhea
☐ Incontinence
☐ Anxiety
☐ Difficulty Sleeping
☐ Weight Loss
☐ Weight Gain
☐ Lightheadedness
☐ Breast Lump
☐ Breast Tenderness
☐ Nipple Discharge
☐ Constipation
☐ Hemorrhoids
☐ Heartburn