advanced women's health specialists

43138 Dequindre Rd, Sterling Heights, MI 48314

Phone: (586) 262-5060 Fax (586) 262-5061

WELCOME LETTER

Welcome to Advanced Women's Health Specialists, PLLC. Enclosed is our welcome packet where you will be asked to sign relevant consent forms. Please read through carefully and provide your signature where requested.

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

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

We value your appointment time which has been set aside to discuss your care with the provider. Please be sure to notify the office if you are unable to arrive at your appointment on time. We ask that you contact the office 24 hours prior to any appointments that need to be rescheduled or cancelled to avoid a $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

43138 Dequindre Rd Sterling Heights, MI 48314

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Ph: 586-262-5060
Fx: 586-262-5061

Patient Information

First Name: _____ Last Name: _____
Middle Name: _____
Date of Birth (MM/DD/YYYY): _____ Age: _____
Social Security: _____
Street Address: _____
City, State, Zip: _____
Home Phone: _____
Mobile: _____
Email Address: _____
Employer: _____ Employer Phone: _____

Emergency Contact

Contact Name: _____ Relationship to Patient: _____
Phone Number: _____

Insurance Information

(Please present your insurance card at the front desk)

Primary Insurance: _____ Member/Contract ID: _____
Group ID: _____
Policy Holder Name: _____ DOB: _____
Relationship to Policy Holder: _____
Secondary Insurance: _____ Member/ Contract ID: _____
Secondary Group ID: _____
Secondary Policy Holder Name: _____ DOB: _____
Secondary Relationship to Policy Holder: _____

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: _____

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TELEPHONE AUTHORIZATION / PHARMACY

Patient Name: _____ **DOB:** _____

- Please indicate below the telephone number **we may use to contact you for appointment reminders, test results, return phone calls, and voicemails:**

Cell Phone: _____ ***Other Phone:*** _____

- Please indicate below **with whom we may speak with** or leave a voicemail regarding your private health information and test results **if you are unavailable:**

Name: _____ ***Phone Number:*** _____

Relationship: _____

- Please indicate with whom we may **NOT** leave a message regarding your private health information:

Name: _____ ***Relationship:*** _____

Pharmacy Name/Location/Phone Number:

_____

_____

Patient Signature: _____ **Date:** _____

Your Rights Under the Privacy Rule

The 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 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 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.
- **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 to 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 HIPPA committee at (517) 484-3000 ext 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 our office.

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Patient Signature: _____ **Date:** _____

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Patient Name: _____ **DOB:** _____

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, emergency care and any other testing medically necessary for the diagnosis and care of the patient.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

e-PRESCRIBE PBM CONSENT FORM

Patient Name: _____ **DOB:** _____

e-Prescribing is defined as a physician's ability to electronically send an accurate, error-free, and understandable prescription directly to the 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 must 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 agree 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 Signature: _____ **Date:** _____

(Representative Signature): _____ **Date:** _____

Relationship to Patient _____

**If you wish to deny consent to prescribe medications electronically, please sign below:*

Consent Denied Signature: _____ **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 in, 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 healthcare 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 patient 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 requests mentioned above. 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, Credit and Debit Cards. 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 determined 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 your appointment must be performed 24 hours in advance. Failure to do so will result in a $50 no-show charge.

Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

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LABORATORY WAIVER

Patient Name: _____ **DOB:** _____

- 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 Advanced Women's Health Specialists, 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. 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 will bill your prenatal visits (13-14 visits), delivery, and postpartum visits separately.

Labs and ultrasounds are not considered to be a 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 regarding 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 insurance first. **

Copays

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 copay. Copays are due at the time of service. A late fee of $25 will be assessed to those not paid at the time of service.

HRA/HSA/Flex Spending

Higher deductible plans (HRA, HSA, and FLEX) encourage patients to share more responsibility for how their healthcare 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, Advanced Women's Health Specialists require 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 the new information. We recommend contacting your insurance company to obtain benefits for pregnancy and verify and precertification of services required.

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

Please keep in mind that although your insurance quotes benefits regarding pregnancy, there is no guarantee of payment. Insurance considers many factors when claims are being adjudicated or processed. Any questions regarding 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, Advanced Women's Health Specialists will bill your insurance for their portion of the global fee.

Tubal Ligation (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: _____ **DOB:** _____

Patient Signature: _____ Date: _____

Hereditary Cancer Yearly Screening Questionnaire

advanced women's health specialists

Please check all that apply

natera | Empower™ Hereditary cancer test

Have you or a close relative **(parents, siblings, children, uncles, aunts, first cousins, grandparents, grandchildren, nieces, nephews, or half-siblings)** had any of the following:

- ☐ **Breast cancer** diagnosed **under age 50**
- ☐ **Ashkenazi Jewish** ancestry with **breast cancer** or **prostate cancer** diagnosed at any age
- ☐ **Three or more** family members with the following cancers on the same side of the family: (breast and/or prostate) or (uterine/endometrial and/or colorectal)
- ☐ **Ovarian, uterine/endometrial, colon, pancreatic,** or male breast cancer diagnosed **at any age**
- ☐ **Metastatic (stage 4 or advanced) prostate cancer**

If you checked ANY of the boxes above, please continue to fill out the rest of the form.

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

If you have never been diagnosed with breast cancer, please complete the following. Your answers may determine if you are eligible for enhanced breast cancer screening.

1. Height ___ft ___in **2.** Weight _____lbs **3.** Have you had children? ☐ Y ☐ N How old were you when you had your first child? _____

4. Approximate age at first menstrual period? ___ **5.** Have you gone through menopause? ☐ Y ☐ N ☐ Ongoing If yes, at approximately what age? ___

6. Are you of Ashkenazi Jewish descent? ☐ Y ☐ N

7. Have you ever used hormone replacement therapy? ☐ Y ☐ N ☐ 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? ☐ Y ☐ N 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? ☐ Y ☐ N ☐ Unknown

If known, complete ONE of the following:
☐ **VAS percentage density** _____-_____%
☐ **Volpara volumetric density** _____-_____%
☐ **BI-RADS ATLAS density:** ☐ Fatty ☐ Average ☐ Heterogeneously dense ☐ Extremely dense ☐ Unknown

Hereditary cancer testing can help you understand if you may have an increased risk for developing cancer.

I want to discuss this with my provider: ☐ Y ☐ N

Patient name: _____ Date of birth: _____

Provider you are seeing today: _____ Clinic name: _____

For more information, text **EMPOWER** to **636363**

CONSENT TO SUBSITUTE *OBSTETRICIAN* AND *GYNECOLOGICAL* CARE AT TIME OF DELIVERY OR AN EMERGENCY

Patient Name: _____

Date of Birth: _____

In engaging you as my obstetrician and/or gynecologist, I understand that if you are unavailable or unable 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. - Anupama Vansadia, M.D. - Emma Gaboury, M.D. - Kayla Busuito, D.O.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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

Physician Signature: _____ **Date:** _____

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Jasmin Ghuznavi, MD, FACOG Kulsoom Jafri, MD

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

Medical History (any new from last visit):

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

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