5333 McAuley Dr., R-5016
Ypsilanti, MI 48197

Phone: (734) 712-1990
Fax: (734) 712-1991

Caritas Center for Women's Health

Caring for Life

Philip V. Fleming, MD
Mary E. Bieniasz, CNP

Date ________________________________

Dear ________________________________,

Welcome to our practice! Your appointment with us has been scheduled as follows:

On_____________________ at_____________ with __________________ at our office in the

Reichert Health Building at St. Joseph Mercy Hospital..

Enclosed you should find:

1. Welcome Letter
2. Patient Information Form
3. Authorization for Services
4. Financial Policy (2 pages)
5. Advanced Directive
6. HIPAA Notice of Privacy Practices
7. Medical History
8. Map to Our Office

Please read all of the enclosed information and bring the ***completed*** forms with you to the appointment. You will be asked for these forms when you check in at the front desk. It is ***very important*** for you to have ***all*** of the attached forms completed before you come to our office for your visit. If they are not completed at the time of your appointment, we may have to reschedule or delay your time to see the doctor.

If you are unable to keep your appointment, please notify our office at least 24 hours in advance. If you have billing/insurance questions, please call the main office at 734-712-1990. *Thank you for your assistance in keeping us on time and helping us to provide appropriate medical care.*

Natural Family Planning

As a new patient to this office, we would like to welcome you and tell you a little bit about what we feel is a very unique and exciting approach to obstetrical and gynecological care. In our desire to offer the best and most respectful gynecological care, we have tried to base our medical evaluation and treatment upon appreciation for and deep understanding of the normal menstrual cycleõ in other words, fertility awareness (often also called Natural Family Planning).

This emphasis gives a whole new perspective to the practice of obstetrics and gynecology and allows us to diagnose and treat problems often in a less interventional way. Fertility awareness allows every woman to know how her body works and to understand the reproductive processes that are integral to her person as a woman.

We believe that a womançs reproductive processes are good and beautiful in themselves, that fertility is a condition of a healthy woman, and that the result of that healthy function, a child, is always a gift worthy of our care, protection, and nurturing. Because of this, we also believe that the best way for couples to plan the spacing and ultimate number of children is by utilizing the knowledge of the fertile and infertile phases of the womançs cycle to either achieve or avoid pregnancies.

The art and science of Natural Family Planning has progressed tremendously in the last 30 years and now provides 98% effectiveness for couples who are trained by experienced teachers and thus is both safer and more effective than oral contraceptives or barrier methods such as condoms.

We realize that this approach may be unfamiliar to you, but we would encourage you to consider it. If you are presently on birth control pills, we would welcome the chance to discuss this with you or send you more information about Natural Family Planning. We also would be happy to see you for any other problem or issue. However, you should be aware that *we will not be able to prescribe or recommend any contraceptive methods at that visit.*

We look forward to seeing you at your appointment.

Sincerely,

Philip V. Fleming, MD

Mary E. Bieniasz, CNP

Demographic Information

Caritas Center for Women's Health

Single Caucasian
Married African-American
Separated Hispanic
Divorced Asian
Widowed Other

Date ______/______/______

Legal Name: ____ Preferred Name: ______________________________________
(How would you like us to address you?)

Spouse/Significant Other Name:_________________________ Spouse/Significant Other Occupation: _______________________

Your Date of Birth (MM-DD-YYYY) _________________________ Your Social Security # ___________________________________

Your Occupation____________________ Your Religion ____________________

Address: ____City_____________________State_________Zip___________________

Primary Care Physician ____ Phone ____________________________________

Contact Information

It is sometimes very important that we contact you. Please complete this section carefully and completely.

Your Home Phone _____________________________ 1 2 3 _____________________________________ sign

Your Cell Phone _____________________________ 1 2 3 _____________________________________ sign

Your Work Phone _____________________________ 1 2 3 _____________________________________ sign

(Please rank in order of preference.)

(Please check box and sign to give us permission to contact you and leave a message.)

Your E-mail ____ _____________________________________ sign

Emergency Contact Name:____ Phone number: ____________________________

(This contact will only be used to get a message to you about contacting us if all your personal contact information fails. NO medical information will be given to the emergency contact.)

Insurance Information

Primary Insurance ____ Effective Date (if known)___________________

Group # ______________________ Contract # or ID ____ Plan code_______________

Copay Amt _____________ Office Visit Coverage? Y N

Subscriber's Name ______________________________________ SS#_______________________ Date of Birth _______________

Secondary Insurance ____ Effective Date (if known)___________________

Group # ______________________ Contract # or ID ____ Plan code_______________

Copay Amt _____________ Office Visit Coverage? Y N

Subscriber's Name ______________________________________ SS#_______________________ Date of Birth _______________

Communication Authorization

☐ Caritas may speak ONLY with me.

or

☐ I give permission for Caritas Center for Women's Health to speak with ________________________________ regarding

☐ my medical care

☐ financial matters

______________________________ ______________

Signature Date

______________________________ Date of Birth________________

Printed Name

AUTHORIZATION FOR SERVICES
CARITAS CENTER FOR WOMEN'S HEALTH, P.C.

1. Consent for medical treatment

I, ____, freely consent to any routine medical, diagnostic, therapeutic or minor surgical procedure that may be recommended by my doctor and performed by, or under the supervision of, my doctor. Specific procedures will be explained to me along with the expected benefits and possible risks prior to any procedure being conducted. I know that I can ask questions at any time and will do so if I have any questions or concerns. I recognize that the practice of medicine and surgery is not an exact science: no one can make promises or assure me about the results of an examination, treatment or procedure that I receive. I also reserve the right to refuse any treatment.

Note: State relationship if patient is unable to sign.

____ ____________________

Patient (18 or older) Signature Date

2. Authorization for Release of Patient Records

I authorize this physician's office to release information contained in my patient records to the party responsible for payment of my care, including but not limited to Medicare/ Medicaid programs, my insurance carrier, my employer's insurance carrier and/ or any other party, including a family member or other individuals whom I have indicated will be responsible for payment of my care. I intend that this authorization for release of patient information to these parties shall extend to any information including alcohol and drug abuse treatment (protected under the regulations in Code 42 of the Federal Regulations, Part 2), and any information about mental health services and social services, including communications made by me to a social worker or mental health professional. Further, this authorization will include release of information about the diagnosis or testing for HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and ARC (AIDS Related Complex) and records of any other communicable diseases.

Note: State relationship if patient is unable to sign

____ _____________________

Patient (18 or older) Signature Date

3. Authorization for Payment of Insurance Benefits

I authorize payment of insurance benefits, including Medicare/ Medicaid benefits to be made directly to this provider. I understand that I am financially responsible to this provider (including physician, nurse practitioner, midwife, physician's assistant) for services not covered or payable by my insurance carrier.

Note: State relationship if patient is unable to sign.

____ ______________________

Patient (18 or older) Signature Date

4. FOR YOUR INFORMATION:

In accordance with the Michigan Public Health Code, if a health professional or other office personnel experiences an exposure to your blood or other body fluids, you may be tested for evidence of the HIV virus. The cost of the test will not be charged to you or your insurance company. The performance and results of this test are confidential. This information will not be released without your written consent, except to those individuals or organizations that have been given access by law, who are also required to keep your records confidential.

Caritas Center for Womenøs Health
Financial Policy

Because payment for services is the responsibility of the patient in the patient/physician relationship, we would like to explain our payment expectations to ensure understanding and compliance.

We (Caritas Center for Womenøs Health) participate with various insurance companies and managed care plans, for which we will file claims on your behalf directly to the insurance carrier for payment. You will be responsible to pay your copay at the time of service.

There are several commercial insurance plans with which we do not participate. If you are covered by one of these commercial insurance plans, we will õcourtesy fileö your claims to them, however you will be responsible to pay a portion of the charges at the time of service. You will also be responsible for any charge not paid for by your insurance.

Insurance copayments and non-covered services are expected to be paid at the time of service. We accept cash, check, Visa, MasterCard, and Discover.

We work closely with Cadillac Accounts Receivable Management, Inc. (CARM) regarding collection activity on delinquent accounts. Our hope is that by working together we can avoid any involvement with CARM in our collection activity.

Additional Fees:

On all patient checks returned for non-sufficient funds or closed account status, there will be a $20.00 fee charged back to the patient. Thereafter, we will be unable to accept any personal checks until the account balance associated service fee is paid in full. In this is a repeated occurrence, we will only be able to accept cash or credit card as a method of payment on your account.

Additional Information:

It is your responsibility to understand the benefits and limitations of your insurance plan. You are also responsible for obtaining any referrals that may be required by your insurance plan prior to your office visit. Any service not covered by your insurance plan due to the lack of a referral will be your responsibility.

By signing below, I acknowledge that I have read and understand the financial policy of Caritas Center for Womenøs Health and agree to the payment terms and my obligations under the financial policy.

____________________________________ ________________
Signature of Patient or Person Responsible for Account Date

____________________________________ ________________
Witness Date

Caritas Center for Womenøs Health
Waiver Form

We would like our patients to know that our physicians do bill for services performed in accordance with billing documentation and coding criteria, which are established by National Coverage Policy determined by Centers for Medicare and Medicaid Services (CMS) and American Medical Association (AMA). We are mandated to comply and follow government and insurance guidelines.

Caritas Center for Womenøs Health provides many different types of medical services to our patients including routine gynecological exams, routine follow up care, obstetrical care, lab work, and various diagnostic testing and procedures. Although some insurance companies will cover most services there are some insurance companies that do not cover certain types of services such as routine/screening exams and testing. Many insurance companies have specific criteria for how frequently an exam, test or procedure may be preformed. More frequent exams, tests, or procedures may not be covered by your insurance and would ultimately be your responsibility.

Our staff makes every effort to assist you in understanding your insurance benefits. Because it is impossible for us to know all of the many different employer group benefits from one employer to the next, we are providing this notice to inform you of the following responsibilities as it related to benefit coverage and payment responsibilities by the patient and by Caritas Center for Womenøs Health/

<u>Caritas Center for Womenøs Health Responsibilities:</u>

1. Caritas Center for Womenøs Health is not responsible for knowing what services are covered by the patientøs insurance plan and is not responsible for informing the patient whether a particular service is covered.
2. Caritas center for Womenøs Health will assist the patient to obtain payment from their insurance company through submitting the claims.
3. Caritas Center for Womenøs Health will resubmit a claim to the patientøs insurance if an error or omission on our part has been made.

<u>Patient Responsibilities:</u>

1. It is the patientøs responsibility to know and understand her own health insurance benefit coverage and limitations.
2. The patient is ultimately responsible for payment for all services provided by the Caritas Center for Womenøs Health, within contractual guidelines.
3. The patient must pay any copayment and the charge for any service not covered by their insurance company at the time of service.

By signing below, I hereby acknowledge and understand my responsibilities as a patient of Caritas Center for Womenøs Health.

________________________________ ________________
Patient or Responsible Party Signature Date

________________________________ ________________
Witness Date

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CARITAS
Caritas Center for Women's Health

Caring for Life

Philip V. Fleming, MD
Mary E. Bieniasz, CNP

Dear Patient:

Michigan Law requires physicians to advise patients about their right to create an advance directive. An advance directive, sometimes referred to as a durable power of attorney, is a document that provides you with the means appoint someone to appear in person to make health care decisions for you, should you become incapacitated.

Our office has advance directive forms available for your review. We ask that you indicate your desire by marking the appropriate box below, sign and date the form and return it to us. If you want the form, our receptionist will give you a copy to take home to read and complete. Once you complete the form, we ask that you return a fully executed copy to us for safe keeping in your medical chart.

[ ] Yes I would like a copy of the advance directive

[ ] No I do not want a copy of the advance directive at this time

____
Patient Name (Please Print)

____ _______________
Patient Signature Date

To be completed only if patient requests advance directive:

I certify that the above patient was given a copy of the advance directive on

_______________________ ______________________________________
Date Staff Signature

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Caritas Center for Women's Health

Caring for Life

Philip V. Fleming, MD
Mary E. Bieniasz, CNP

THIS AREA BLANK

I have received a copy of the Caritas Center for Women's Health, P.C.'s
HIPAA NOTICE OF PRIVACY PRACTICES

______________________________________ ________________
(Patient Signature) (Date)

______________________________________ ________________
(Patient Name- Printed) (Date)

****

Patient refused to sign- witnessed by:

______________________________________ ________________
(Caritas Employee Signature) (Date)

EFFECTIVE DATE OF THIS NOTICE: APRIL 9, 2003

Caritas Center for Women's Health

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NOTICE OF PRIVACY PRACTICES

As Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your medical information is personal and we are committed to protecting your privacy. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your medical information and what rights you have regarding information. If you have any questions, please contact Jill Tait.

We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that our practice has created or maintained and for any generated in the future. Our practice will post a copy of our current Notice in our office in a visible location and you may request a copy of our most current Notice at any time.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe the purposes for which we may use and disclose your medical information. We routinely use your medical information inside our office for these purposes without any special permission. For clarification, we have included some examples. Not every possibility is specifically mentioned. However, all of the ways we are permitted to use and disclose your medical information will fit within one of these general categories.

TREATMENT. Our practice may use and disclose your medical information to treat you. Common reasons for use and disclosure may include performing exams, ordering or performing tests, ordering prescriptions, referring you to other medical professionals, or obtaining copies of information from other providers. Additionally, we may disclose your medical information to others who may assist in your care, such as your spouse, children, or parents.

PAYMENT. We may use and disclose your medical information in order to bill and collect payment for services. For example, we may provide your insurer with treatment information to certify eligibility. We also may use and disclose your medical information to obtain payment from third parties that may be responsible for costs, such as family members.

HEALTH CARE OPERATIONS. Our practice may use and disclose your medical information to operate our business. Examples may include using your medical information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice.

APPOINTMENT REMINDERS. Our practice may use and disclose your medical information to contact you and remind you of an appointment.

TREATMENT OPTIONS AND HEALTH RELATED BENEFITS. Our practice may use and disclose your medical information to inform you of potential treatment options or health-related benefits or services that may be of interest to you.

DISCLOSURES REQUIRED BY LAW. Our practice may use and disclose your medical information when we are required to do so by federal, state, or local law. For example, disclosure may be required by WorkersøCompensation statues and various public health statues in connection with required reporting of births and deaths, certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

HEALTH OVERSIGHT ACTIVITIES. Our practice may use and disclose your medical information to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

LAWSUITS AND SIMILAR PROCEEDINGS. If you are involved in a lawsuit or similar proceeding, we may use and disclose your medical information in response to a court or administrative order or to defend the office. We also may disclose your information in response to a discovery request, subpoena, or other lawful process by another party involved, but only if we have tried to inform you of the request or to obtain an order protecting the information the party has requested.

LAW ENFORCEMENT AND/OR NATIONAL SECURITY. We may disclose your medical information for law enforcement purposes. For example, we may provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened elsewhere. Further, we may disclose your medical information to federal officials for intelligence and national security activities authorized by law including to protect the President or other officials including foreign heads of state, to conduct investigations, or for military purposes.

DECEASED PATIENTS. Our practice may release medical information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs or, when requested, to facilitate organ, eye or tissue donation.

RESEARCH. Under certain circumstances, we may use and disclose your medical information for health related research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.
SERIOUS THREATS TO HEALTH OR SAFETY. Our practice may use and disclose your medical information to prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
INCIDENTAL DISCLOSURES. Our practice may disclose your medical information if it is an unavoidable byproduct of conducting business, including receiving services from cleaning personnel and those maintaining or repairing equipment.
BUSINESS ASSOCIATES. Our practice may disclose your medical information to business associates who perform health care operations for us and who commit to respect the privacy of your health information.

Other uses and disclosures of your medical information not covered by the Notice will be made only with your written authorization. If you provide us such an authorization, you may revoke it, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your information for the reasons covered by the authorization.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following right regarding the medical information that we maintain about you:

CONFIDENTIAL COMMUNICATIONS. You have the right to request that we communicate with you in a particular manner. For instance, you may ask that we contact you at home rather than work. To request a type of communication, you must make a written request to the division contact listed on page one of this notice. We will accommodate reasonable requests.
REQUESTING RESTRICTIONS. You have the right to request a restriction in our use or disclosure of your medical information for treatment (except in emergencies or when required by law), payment or health care operation. We are not required to agree to your request; if we do agree, we are bound by our agreement. You also have the right to request that we restrict our disclosure of your medical information to only certain individuals involved in your care. To request a restriction, you must make your request in writing to the contact listed on page one.
INSPECTION AND COPIES. You have the right to see and copy your medical information. You must submit your request in writing to the contact listed on page one. Our practice may charge a fee for the costs of copying and mailing your information. By law, our practice may deny your request to see and/or copy your information in certain limited circumstances, however, you may request a review of our denial. For information regarding such a review, contact the contact listed on page one of this notice.
AMENDMENT. If you feel that medical information we have about you is incorrect or incomplete, you may send us a written request to amend the information. The request must include a reason supporting your request and should be sent to the contact listed on page one. We may deny your request if it is not in writing or does not include a reason. Further, we may deny your request if you ask us to amend information that is, in our opinion, accurate and complete, not part of the information kept by us, not part of the medical information which you would be permitted to see and copy, or if it was not created by us.
LIST OF DISCLOSURES. You have the right to request a list of disclosures our practice has made of your medical information for non-treatment, non-operations purposes. Use of your medical information as part of the routine patient care in our practice is not required to be documented and, therefore will not be on the list. Further, the list will not include disclosures made with your authorization, incidental disclosures or those required by law. In order to obtain a list of disclosure, you must submit your request in writing to the contact listed on page one. All requests must state a time period (not to exceed six years) and may not include dates before April 14, 2003. You are entitled to one such list per year free of charge; additional lists may require payment.
RIGHT TO A PAPER COPY OF THIS NOTICE. You are entitled to receive additional copies of this notice of privacy practices at any time. To obtain a copy of this notice, please call our office at the telephone number listed on page one.
RIGHT TO FILE A COMPLAINT. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, write to the contact listed on page one. This office will not penalize you in any way for submitting a request.

Gyn History: Menstrual Information
Sexual History

Menstrual History:

Age at first menses: ____________ Usual cycle length: _____________ # days of flow: ____________

Pain with periods? Yes No Heavy flow? Yes No

Any other problems with your periods____

Family Planning History:

Current method of family planning: ____

Methods used in the past:

____ Birth control pills ____ Condom/Barriers ____ Depo-Provera

____ IUD ____ Diaphragm ____ Norplant

____ Natural Family Planning (which method?_________________________)

Sexual History:

Age at first intercourse _____________ Age at first pregnancy _____________

# of lifetime sexual partners _____________ Do you have pain with intercourse? Y N

Have you has a new sexual partner in the last 3 months? Y N

Any history of STDs? (genital warts, condyloma, HPV, Herpes, Chlamydia, or Gonorrhea?) Y N

Any other issues or concerns you'd like to discuss with the doctor:

____

____

____

____

____

____

GYN HISTORY: MEDICAL / SOCIAL HISTORY

Medical History: Have you ever had: please check yes or no and then explain.

	Y	N	Explanation
Heart attack/angina (chest pain)	___	___	___
Heart murmur	___	___	___
Rheumatic Heart Disease	___	___	___
High Blood Pressure	___	___	___
Migraine/ seizures	___	___	___
Lung disease (tb, asthma)	___	___	___
Diabetes	___	___	___
Thyroid disease	___	___	___
Liver disease (hepatitis, cirrhosis)	___	___	___
Stomach, bowel, gall bladder disease	___	___	___
Bleeding problems	___	___	___
Transfusions	___	___	___
Mental illness	___	___	___
Cancer	___	___	___

Social History/ Habits

	Y	N	Explanation
Do you smoke? If yes, how much?	___	___	___
Do you drink alcohol? How often?	___	___	___
Do you use street or recreational drugs?	___	___	___
Do you eat a vegetarian diet?	___	___	___
Do you exercise regularly? How much?	___	___	___

Have you been hit, slapped, or beaten or otherwise hurt by anyone? ___

Caritas Center for Women's Health

Medical History

Does not include pregnancy-related events.

No.	Date	Surgeries/Hospitalizations	Physician/Provider
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Family History

	High Blood Pressure	Stroke/ Blood Clots	Diabetes	Breast Cancer	Ovarian Cancer	Uterus Cancer	Colon Cancer	Other	Com-ments	Update
Father										
Mother										
Sisters										
Brothers										
Mat. GM										
Mat. GF										
Pat. GM										
Pat. GF										
Others										

Comments ____

____

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____