Welcome to BRUCE E. WEST, M.D.
PROFESSIONAL CORPORATION

Obstetrics and Gynecology

As a new patient, we require you to fill out the following information prior to being seen by Dr. West.

- □ Consent to Treatment
- □ Patient Registration Form and Verification of Insurance
- □ Signed Financial Policy Statement
- □ Patient Information and Acknowledgement

Dr. West is an obstetrition as well as a gynecologist, therefore he must occasionally attend to unforseen deliveries or emergencies. Our office staff will make every attempt to contact you if your appointment will be delayed. You may also consider calling just before you leave to verify that we are running on time. We apologize for any inconvenience this may cause you.

We participate with most major insurance companies. As a courtesy to you, we will bill your insurance company for the care you receive. Having current and accurate insurance information allows us to process your claim promptly and correctly. It is your responsibility to know what services your insurance plan and policy covers, i.e. which labs, procedures, treatments, radiologists and doctors your insurance will accept.

If your insurance company requires a referral or prior approval for lab tests, radiology, or hospitalizations, please obtain the necessary authorizations prior to scheduling your appointment. Alerting us when Dr. West orders a test which may require pre-authorization may reduce or eliminate additional out-of-pocket cost to you.

As described in our Financial Statement, you are responsible for paying all co-pays, deductibles and non-covered services as specified by your insurance plan coverage in effect at the time of service. We accept cash, personal checks, and credit cards for payment.

We appreciate your choosing BRUCE E. WEST, M.D., P.C. for your obstetrics and gynecological care. Please let us know if you have any insurance or billing questions. We welcome the opportunity to meet you and will work hard to serve your needs.

Very Sincerely Yours,

Staff

BRUCE E. WEST, M.D.

PROFESSIONAL CORPORATION

General Consent to Treatment

Patient's Name: ____________________________ Date of Birth: _______________

1. Consent: I request and authorize medical treatment as may be deemed necessary and appropriate by the physician, designees and assistants participating in my care. This may include diagnostic, radiology and laboratory procedures, anesthesia, therapeutic procedures, drugs and medical or nursing care.

2. Release of Information: I understand the confidentiality of all medical records and communications will be protected to the extent of the law as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. In light of this, I authorize Bruce E. West, M.D., P.C. to release pertinent information and/or copies of medical records to: 1) Health care facilities and agencies or physicians for the purpose of assuring continuity of care; 2) Third party payers or insurance companies which are responsible in whole or in part for my office bill; and/or 3) Review agencies which analyze the office charges for third party payers and insurers. I understand such information may include Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), Hepatitis, and substance abuse records. *

3. Human Immunodeficiency Virus and Hepatitis B (HBV) Testing: I understand and agree that, in accordance with State law, an HIV or HBV test may be performed upon me in the event a health care worker sustains a significant exposure to my blood or body fluids. The results of any test will be treated confidentially.

4. Testing and Disposal of Specimens and Tissues: I authorize Bruce E. West, M.D., P.C. to retain, preserve, or use for research, scientific or teaching purposes; and to dispose of any specimen or tissue remaining after completion of a clinical treatment or procedure.

5. Valuables: I release Bruce E. West , M.D., P.C. from responsibility for personal articles which I have with me during the time I am at the facility. I understand this includes clothing, eyeglasses, dentures, jewelry, money and all other personal items.

6. Payment: I assign and authorize payment from my insurance company directly to Bruce E. West, M.D., P.C. for services rendered. I agree to pay, at the time of service (or on an interim basis agreed upon at the time of service) all charges not covered by my insurance company (including deductibles, co-payments, and services not specifically outlined in my health care contract). I understand that it is my responsibility to pay Bruce E. West, M.D., P.C. for all services rendered irrespective of any dispute between myself and insurance companies.

7. No Guarantees: I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made as to the results of the care and treatment which I have hereby authorized.

*For additional information on HIPAA and/or the release of information you may request a copy of our **Notice of Privacy Practices** from our Privacy Officer: **Tracey Gardner,** Lahser Medical Campus, 27177 Lahser, Suite 100, Southfield, Michigan 48048. Telephone (248) 352-8970. FAX (248) 352-8933. **E-mail: TGardner@BWestMDPC.com**
You may also find this information on-line at http://www.BWestMDPC.com

I have read this form, or it has been read to me, and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw this consent at any time.

______________________________ ____________________

Patient Signature Date

______________________________ ____________________

Witness Signature Date

BRUCE E. WEST, M.D.
PROFESSIONAL CORPORATION

Patient Registration Form

Please call **(248) 352-8970** for assistance.

PATIENT INFORMATION

Legal Name: Last	First	Initial	Social Security #
Address			Drivers License #
City	State	Zip	Marital Status **M S D W**
Work Phone # Extension	Home Phone #		Cell Phone #
E-Mail Address (optional)			Date of Birth
Employer or School			Occupation
Employer or School Address			Primary Care Physician
How did you hear about us?			
Emergency Contact	Relationship		Contact #

Please provide your current insurance card(s) and driver's license so that a copy may be made for your file.

Authorization to pay Benefits to the Physician and Release of Information:

I hereby instruct and direct my Insurance Company to pay by check made out and mailed to Bruce E. West, M.D., P.C.. If my current policy prohibits direct payment to my doctor, then I hereby also instruct and direct you to make out the check payable to me and Bruce E. West, M.D., P.C. Send the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original.

I authorize Bruce E. West, M.D., P.C. to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered.

I certify that the information above is true and correct to the best of my knowledge. I recognize and accept responsibility for services rendered regardless of insurance coverage. I understand that my payment is expected at the time of service. This includes, but is not limited to co-insurance, co-payment, deductible and non-covered services.

Policy Holder Signature ________________________________ Date ______________

Spouse Signature ________________________________ Date ______________

Medicare Authorization

I hereby authorize payment of Medicare benefits to be made directly to Bruce E. West, M.D., P.C., for any services rendered to me by providers employed by that corporation. I authorize any holder of medical or other information about me to release to Bruce E. West, M.D., P.C. and its agents any information needed for the purpose of determining these benefits. I understand that this authorization is in effect unto revoked, in writing, by me.

Beneficiary Signature ________________________________ Date ______________

Beneficiary Signature ________________________________ Date ______________

Lahser Medical Campus, 27177 Lahser, Suite 100, Southfield, MI 48034

BRUCE E. WEST, M.D.

Financial Policy

Thank you for choosing BRUCE E. WEST, M.D., P.C. as your health care provider. We are committed to your successful treatment. In order to comply with Centers for Medicare and Medicaid guidelines (formerly Healthcare Financing and Administration), the Health Insurance Portability and Accountability Act (HIPAA) and Michigan State Regulations, the following is a statement of our Financial Policy.

Dr. West participates with most major insurance companies. As such, we are required to verify health insurance coverage each visit. Having your current and accurate insurance information allows us to process your insurance claim promptly and correctly. Many insurance companies have fixed allowances or percentages based on your contract with them. We are not a party to that contract. Therefore any disputes between you and your insurance company will not affect your obligation to pay your bill.

1. It is your responsibility to pay the deductible, co-insurance and other balances not covered by your insurance plan on the day service is rendered. Please be aware some of the services provided to you may not be considered reasonable and necessary under the Medicare Program, Medicaid and other medical insurance guidelines. You will be responsible for these balances.
2. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
3. We will assist you in receiving reimbursement from your insurance company where we are a participating provider, but you are responsible for your bill. You are also responsible for knowing your insurance policy and plan.
4. The adult accompanying a minor to our office and the parents (or guardians) are responsible for full payment.
5. You must obtain any necessary prior authorizations and/or referrals required by your insurance company prior to scheduling an appointment.
6. Any balance outstanding for more than 90 days will be sent to an outside collection agency.
7. A charge of $30 will be assessed for each returned check to cover the corresponding bank charge and related costs.
8. For your convenience, we accept cash, personal checks, Visa or MasterCard.

If you have any questions regarding our Financial Policy, please contact the office billing clerk at (248) 352-8970 **prior** to signing this form.

I have read, understand and agree to comply with this Financial Policy.

____
Printed Name

____ ____________________
Patient Signature (or person responsible for the account) Date

Lahser Medical Campus
27177 Lahser, Suite 100
Southfield, MI 48034

Fax: (248) 352-8933
Ans. Service: (313) 396-0578
Email: WPC@BWestMDPC.com

BRUCE E. WEST, M.D.
Obstetrics and Gynecology

Patient Information and Acknowledgement

Advance Directive

In 1990 the State of Michigan enacted a law that states that you have the right to determine the direction of your medical care in advance, should you ever lose the ability to make medical decisions due to unforeseen injury or incapacitation. A self-determining advance directive is a written statement you make about future treatment choices if you become unable to make those decisions. An advanced directive is also known as the Durable Power of Attorney of Healthcare (D.P.O.A.) or a Living Will.

Do you currently have an Advance Directive? Yes No

I have been informed that an Advance Directive is a voluntary option that I might wish to consider.

Patient Signature ____ Date ________________

Office Staff ____ Date ________________

Laboratory Services

Laboratory services are separate from your professional services.

Your insurance information will be given to the lab to process any lab specimens such as Pap Smears, cultures or other lab work. Your insurance company will be billed separately for the laboratory services. In turn, the lab will contact and/or bill you for any uncovered services.

If you have any questions regarding lab billing, please contact the lab directly.

Every effort will be made to make sure that your services are covered under your insurance plan, however, it is your responsibility to know what your plan does or does not cover.

I understand and agree to comply with the statement above.

Patient Signature ____ Date ________________

Organ Donation

It is important that your family be made aware of your preferences about organ donation. Your legal next-of-kin will be responsible for informing the health care team of your wishes, as well as providing permission for organ donation if such permission is granted.

Lahser Medical Campus
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We care for the complete needs of women, from adolescence to menopause.