Ob/Gyn
Associates of Holland P.C.

WELCOME TO OUR OFFICE

We are pleased that you have chosen our office for your health care. The physicians in this practice are specially trained obstetricians/gynecologists. Our nurse practitioners and nurse midwife have advanced training in women's health and primary care. They work closely with our physicians when providing your care. We are dedicated to delivering thoughtful comprehensive women's care. Our clinical and clerical support staff round out our team of health care professionals. We are all working together to exceed your healthcare expectations.

OFFICE HOURS

Our office is open from 8:00 am until 5:00 pm, Monday through Friday. We do not close our office during the lunch hour. We do close our office for traditional holidays throughout the year. Our telephone message will reflect this when appropriate.

APPOINTMENTS

Our office visits are by appointment. When making an appointment, the receptionist will need information from you so that we can provide you with the proper amount of time for your visit. If you find that you cannot keep your appointment, we would appreciate it if you would call the office 24 hours in advance. With this notice, we are better able to find another patient in need of your appointment time.

TELEPHONE CALLS

We welcome and encourage calls to the office if you have a problem or question. Non-emergent calls can be made between 8:00 am and 5:00 pm Monday-Thursday and 8:00 am and 4:00 pm on Friday. Please keep in mind that our highest volume call times are first and last hours of the day. We encourage you to avoid these high-volume call times whenever possible. You can also avoid making phone calls to the office by using our patient portal.

PATIENT PORTAL

Using our patient portal is an excellent way to make the best use of your time. Through the portal, you are able to request appointments, message your provider, see your medical records, and more. Visit our website at www.obgynholland.com to access our patient portal. Once at our website you will see the patient portal button at the top right side of our website.

AFTER HOURS

If a problem occurs during our normal telephone hours (8-5 M-Th, 8-4 F) please call us at (616)392-5973. When our telephone system is turned off for the day or the weekend, you can access our after-hours answering service through our phone number, or you may contact them directly at (616) 377-4800. Our answering service will take your name, number, and the nature of the problem and relay this information to the physician on call. Please remember that there may be times when the physician is busy with another patient emergency. We ask for your understanding during these times. If you haven't had a return call from the physician within 20 minutes, please contact the answering service again for follow up. The answering service should only be used in true cases of emergency. Non-emergent issues such as prescription refills or appointment scheduling should be managed during our regular office or telephone hours of business.

HOSPITALS

Our physicians practice exclusively at Holland Hospital.

PRESCRIPTIONS

Requests for refills on prescriptions should be made during our normal office and/or telephone hours. Please allow 24-48 hours for all prescription refills. The physicians prefer not to renew prescriptions and generally will not renew prescriptions when called into our after-hours answering service. They may be unable to examine your record and under most circumstances these requests can be managed during normal business hours.

TEST RESULTS

You will be contacted regarding your test results, even if they are normal. Of course, it is important for you to call the office if you do not receive notification within a reasonable amount of time.

PRIMARY CARE & OTHER HEALTH CONCERNS

Unless you have insurance coverage through Priority Health and are currently on our primary care patient roster, we will be unable to provide health care for you for such concerns as cough, urinary tract infections, back pain, and other acute illnesses. You will need to see your primary care provider for things unrelated to obstetrics or gynecology. If your primary care physician deems it appropriate for you to be seen by our office, a referral will be made to our office.

REFERRALS/CONSULTATIONS

When you are referred for care by another physician, a report will be sent to that physician at intervals during treatment or upon completion of treatment. It is necessary that we receive medical records from your referring physicians so that we have all of the information necessary to make a medical decision regarding your care.

CONFIDENTIALITY

We observe the strictest policies when it comes to protecting your health information. Except for information required to provide treatment to you or to receive payment for services we have provided to you, we will not release your protected health information without your written permission.

PAYMENT POLICY

Co-payments and any outstanding balances are expected at the time of service. Please come to every appointment prepared to provide our staff with a photo I.D. and a current copy of your insurance information. Payment arrangements can be made when appropriate. Please review our financial policy for more details.

PHONE/FAX NUMBER

Phone number: (616)392-5973 Fax number: (616)392-1646

LOCATIONS

We have four locations to serve you. Please visit our website at www.obgynholland.com for location details.

WEBSITE

Our website provides you with very useful information. Please visit our website to discover information that is of interest to you at www.obgynholland.com.

OUR PROVIDERS

James Gerard, MD	Mark Lenters, MD	Mary Gootjes, MD	Kiersten Krause, DO
Sarah Strong, DO	Michael Werkema, MD	Rachael Fizer, DO	

OUR MID-LEVEL PROVIDERS

Debra DeGram, CNM	Jodee Danhoff, FNP-C	Andrea Kamphuis, FNP-C	Jacqueline Heflin, WHNP-BC

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PATIENT REGISTRATION

Today's Date:_____

PATIENT INFORMATION PLEASE PRINT

Name (First/M.I./Last):_____ Maiden Name:_____
Address:_____ City/St/Zip:_____
Marital status:_____ Date of birth:_____ Social Security #:_____
Phone #'s: home:_____ cell:_____ work:_____
Preferred phone number (circle one): *home cell work* Email:_____
Preferred language:_____ Preferred Pharmacy:_____
Employer:_____ Occupation:_____
Primary Care Physician:_____ Ob/Gyn Physician:_____

EMERGENCY CONTACT

Name_____ Phone #:_____ Relationship:_____

RACE

☐ Black/African American ☐ White ☐ Asian ☐ American Indian or Pacific Islander
☐ Unknown ☐ More than one race ☐ Decline to respond

ETHNICITY

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to respond

INSURANCE INFORMATION Please provide your current insurance card each time that you are seen.

Primary Insurance:_____
Policy Holder's Name (if other than patient):_____
Policy Holder's date of birth (if other than patient):_____
Relationship to patient: *spouse parent other*_____

Secondary Insurance:_____
Policy Holder's Name (if other than patient):_____
Policy Holder's date of birth (if other than patient):_____
Relationship to patient: *spouse parent other*_____

RESPONSIBLE PARTY FOR PAYMENT

Required only for patients under the age of 18.
Name:_____ Date of birth:_____
Address:_____
Phone number:_____ Relationship to patient:_____

Patient's Signature:_____ Date:_____

Guardian's Signature (if applicable):_____ Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Ob/Gyn Associates of Holland, PC, is concerned about maintaining your confidential information. We will not release your information without your written permission except as outlined in our HIPAA policy. Ob/Gyn Associates of Holland, PC reserves the right to modify its privacy practices from time to time as required. By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Ob/Gyn Associates of Holland, PC.

_____ _____

Signature of patient or patient's representative Date

AUTHORIZATION TO OBTAIN MEDICATION HISTORY

By signing below, I authorize Ob/Gyn Associates of Holland, PC to obtain/download my medication history from pharmacies and/or pharmacy benefit managers. This authorization will allow my physician to check drug-to-drug interactions for any new prescriptions he/she may prescribe, and to facilitate electronic pharmacy prescriptions. I understand that this authorization will remain in effect until revoked by me in writing.

_____ _____

Signature of patient or patient's representative Date

AUTHORIZATION TO TREAT

I agree to all care and treatment (including procedures when necessary) provided to me by the healthcare providers at Ob/Gyn Associates of Holland, PC. I understand that my care will be explained to me and that I will be a part of the decision making process. I understand that I should ask questions about my care to be certain that I understand the plan of care.

_____ _____

Signature of patient or patient's representative Date

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FINANCIAL POLICY

INSURANCE: We participate with most but not all insurance companies. You are expected to pay your co-pay at every visit. If you do not have insurance you may be required to pay in full, make payment arrangements with our billing department, or re-schedule your appointment. Filing insurance claims is a courtesy that we extend to our patients. All charges are your responsibility. Your insurance policy is a legal contract between you and your insurance company. We are not party to that contract. It is important to keep your billing information up-to-date. You must present a CURRENT copy of your insurance at each visit and communicate any changes in your personal information. If we have not received payment from your insurance company within 60 days of the date of service, we reserve the right to request payment in full.

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not on coverage by insurance companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance company is inappropriate and is considered insurance fraud.

PRE-AUTHORIZATION/COST ESTIMATES/BENEFIT COVERAGE: Upon your request, our office will assist you to the best of our ability with pre-authorization requirements by your insurance company, cost estimates, and benefit coverage inquiries. We will relay this information to you as relayed to us by your insurance company.

NON-COVERED SERVICES/DEDUCTIBLES/CO-INSURANCES: Non-covered services are services that your insurance company has deemed as a service that they do not cover under any circumstance. You are responsible for the entire fee for a non-covered service. If we participate with your insurance company we will accept payment for covered services after you have paid any deductible or co-insurance required by your insurance company.

PAYMENT/NON-PAYMENT/FEES: We encourage you to contact our billing department as soon as possible to make payment arrangements. We accept cash, personal checks, Visa, MasterCard, American Express, and Discover. If your account becomes past due and is forwarded to an outside collection agency, your account will be assessed a 20% collection fee based on your remaining balance. There will be a $25 service charge for all returned checks.

REFUNDS: Patient/guarantor credits in amounts less than $25 will be retained on current patient accounts. The credit will be used toward future balances unless you request a refund. Credits greater than $25 will automatically be refunded to the patient/guarantor.

MEDICAL RECORDS/FMLA/DISABILITY FORMS: We charge an administrative fee for processing medical records, FMLA forms, and disability forms.

I have read and understand that I am financially responsible for all services provided to me and all costs of collection incurred by Ob/Gyn Associates of Holland PC. I agree to make payments at the time of service when applicable. I authorize the release of any medical information necessary to process my insurance claims. I understand that I am responsible for all amounts unpaid or not authorized by my insurance company.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Patient's printed name Date of birth

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MEDICAL RECORDS RELEASE-Limited Patient Authorization for Disclosure of Protected Health Information
Please print all information. Form must be signed and dated.

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

Maiden Name: _____ **Date of Birth:** _____

I authorize Ob/Gyn Associates of Holland to disclose or provide protected health information about me to the individual/entity listed below:

Records are to be sent **TO**:

Individual/Entity Name: _____
Address: _____
City:_____ State:_____ Zip Code: _____
Phone _____
Fax* _____

Records are to be sent **FROM**:

Individual/Entity Name: _____
Address: _____
City:_____ State:_____ Zip Code: _____
Phone _____
Fax* _____

* **Secure Communication** - Note that some fax and email transmission methods are not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not include a recipient fax number or email address if this is of concern to you.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

- ☐ office notes
- ☐ lab results, pathology reports
- ☐ x-rays
- ☐ financial history report
- ☐ nursing home, home health, hospice, and other physician records
- ☐ record of HIV and communicable disease testing
- ☐ record of mental health or substance abuse treatment
- ☐ Only disclose the following: _____

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Transferring primary care OR gyn care (circle one) to:_____
☐ Transferring pregnancy care to:_____ ☐ Other (please specify):_____

- This authorization will expire at the end of the calendar year,,unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written recuest to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

_____ _____
Patient or Authorized Representative Signature Date

You have the right to receive a copy of signed authorizations upon request.
REV 12/2021