Ob/Gyn
Associates of Holland P.C.

WELCOME TO OUR OFFICE

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

OFFICE HOURS

Our Holland (south side and north side) offices are open from 8:00 am until 5:00 pm (or last patient has been cared for), Monday through Friday. If we finish our day a little early, we may leave early as well. Our South Haven and Grand Haven offices have shortened schedules. Please check our hours on our website. We do close for traditional holidays throughout the year. Our telephone message will reflect this when required.

APPOINTMENTS

Our office hours are by appointment. When making an appointment, our team members 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 could call the office 24 hours in advance whenever possible. 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. Please make non-emergent calls from 8:00 am - 12 pm, and 12:45 pm - 4:30 pm Monday-Thursday. On Friday, phones are on from 8:00 am – 12pm and 12:45 pm - 4:00 pm. Please keep in mind that our high-volume call times are between 8 and 9am and again during the last hour of the day. We encourage you to avoid these high-volume call times whenever possible.

PATIENT PORTAL

Using our patient portal is an excellent way to make the best use of your time. Through the portal, you can 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 home page.

AFTER HOURS

If a problem occurs during our normal telephone hours, please call us at (616)392-5973. When our telephone system is turned off during lunch, for the day, or for the weekend, please call our answering service with emergencies only at (616)377-4800. Our answering service will take your name, number, and the nature of the problem and relay this information to the on-call doctor. Please remember that there may be times when the physician is busy with an emergency or with other patients. 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 to follow up. The answer service should only be used in case

of emergency. Non-emergent issues such as prescription refills or appointment scheduling should be managed during our 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 when called into our after-hours answering service as they may be unable to examine a patient's record.

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

We will gladly provide health care for your obstetric or gynecological concerns. For other concerns such as a cough, back pain, or other acute illness you will need to be seen by your primary care provider.

REFERRALS/CONSULTATIONS

When you are referred to us 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 the necessary information 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 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

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.

LOCATIONS

North Holland:
3290 North Wellness Drive, Building D, Suite 120
Holland, MI 49424
Ph (616)392-5973
Fx (616)392-1646
Our north office is located just off of US 31 toward the east on Riley Street.

South Holland:
664 Michigan Avenue
Holland, MI 49423
Ph (616)392-5973
Fx (616)392-1646
Our south office is located one block south of Holland Hospital.

Grand Haven:
1475 Robbins Rd, Suite 100
Grand Haven, MI 49417
Ph (616)392-5973
Fx (616)392-1646
Our Grand Haven office is located to the east of 31 on Robbins Road.

South Haven:
749 Phillips Street
South Haven, MI 49090
Ph (616)392-5973
Fx (616)392-1646
Our South Haven office is located west of 31 (exit 20), west on Phoenix Street, south on Phillips Street.

OUR PHYSICIANS

James Gerard, MD	Mary Gootjes, MD	Mark Lenters, MD
Kiersten Krause, DO	Sarah Strong, DO	Kristyn Oswald, MD
Matthew Fallon, MD	Abbie Huff, DO	Kami Palmer, MD (hospital only)

OUR ADVANCED PRACTICE PROVIDERS (APP's)

Anna Welsch, WHNP-BC	Tabitha Grady, WHNP-BC	Ashley Todd, WHNP-BC

REV 8/2025

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PATIENT REGISTRATION

Today's Date:_____

Patient ID #:_____

OFFICE USE ONLY

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:_____

Employer:_____ Occupation:_____

Primary Care Physician:_____ Ob/Gyn Physician:_____

EMERGENCY CONTACT

Name_____ Phone #:_____ Relationship:_____

RACE □ African American □ White □ Asian □ American Indian or Pacific Islander
□ More than one race □ Unknown □ 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:_____

Continued on next page.

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

Reviewed 5.2024

Ob/Gyn
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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 $10 may be retained on current patient accounts. The credit will be used toward future balances unless you specifically request a refund. Credits greater than $10 will automatically be refunded to the patient/guarantor when identified.

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

Reviewed 5/2024

Ob/Gyn
Associates of Holland P.C.

Patient's Authorization to Disclose or Release Protected Health Information to Others

Please print all information. Form must be signed and dated each year.

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

SSN (last four digits):_____ **Date of Birth:** _____

Purpose of request (who will be authorized to receive information) - I authorize Ob/Gyn Associates of Holland PC to disclose or provide protected health information about me to the individual(s) listed below.

Who is authorized to discuss or receive my protected health information?

1. _____

Name **Relationship** **Phone Number**

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the person 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 (previous 3 years only).
☐ confirm and reschedule appointment times
☐ nursing home/home health/hospice/other physician records
☐ record of HIV and communicable disease testing
☐ record of mental health or substance abuse treatment
☐ Only the following: _____

2. _____

Name **Relationship** **Phone Number**

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the person 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 (previous 3 years only).
☐ confirm and reschedule appointment times
☐ nursing home/home health/hospice/other physician records
☐ record of HIV and communicable disease testing
☐ record of mental health or substance abuse treatment
☐ Only the following: _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization 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 request 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.

☐ **I DO NOT WISH TO HAVE MY PROTECTED HEALTH INFORMATION RELEASED.**

_____ _____

Patient or authorized representative signature **Date (valid for one year from this date)**

South office: 664 Michigan Ave. Holland, MI 49423 **Grand Haven**: 1475 Robbins Rd. Grand Haven, MI 49417
North office: 3290 N Wellness Dr Suite 120 Building D, Holland, MI 49424 **South Haven**: 749 Phillips St. South Haven, MI 49090
P: (616) 392-5973 F: (616) 392-1646