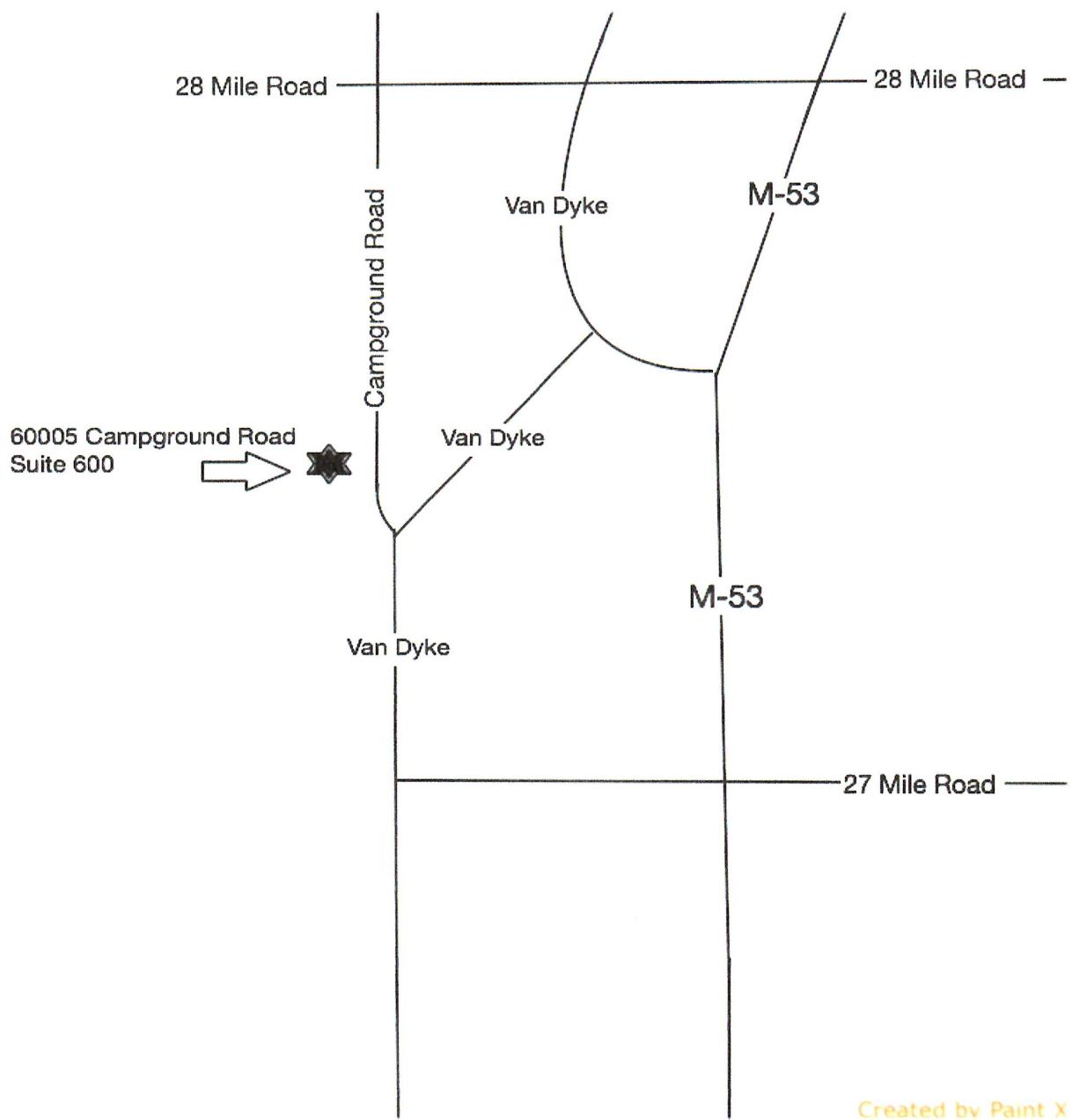


Affiliated
With
You

Gregory E. Gould, D.O., P.C.

60005 Campground Road, Suite 600
Washington, MI 48094
Call: (586) 372-3500

Delivering
A New
Standard of Care



**Gregory E. Gould, D.O., P.C.
6000 Campground Road, Suite 600
Washington, MI 48094**

I have chosen to follow with Gregory E. Gould, DO. I was in no way solicited to follow with this practice.

Name

Signature

Date

ACKNOWLEDGMENT AND CONSENT

I understand that Dr. Gould's Office will use and disclose Health Information about me.

I understand that my Health Information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that "This Practice" may use and disclose my health information in order to :

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how "This Practice" will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the health practices followed by the employees, staff, and other office personnel of "This Practice", and my rights regarding my health information.

I understand the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices in effect and a revised copy will also be posted in the waiting /reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that "This Practice" is not required by law to agree to such request.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Patient's Signature _____

Date _____

Signature of Patient's Representative _____

HIPAA Disclosure Form

Hospital: _____ Doctor: _____

Patient Name: _____ Date: _____

Listed Address: _____

Preferred Correspondence Address: _____

Listed Phone No. _____ Preferred Phone No. _____

Listed Email Address: _____

Preferred Email Address: _____

Would you like our correspondence with you to be marked "Confidential"? Yes No

May we identify ourselves over the phone? Yes No May we leave messages? Yes No

I, the Patient, hereby authorize the doctor and/or hospital listed above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____ DOB: _____ Relationship: _____

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor: _____ Clinic: _____ Phone: _____

As a courtesy, Dr. Gregory Gould D.O. P.C., will file claims to your primary and secondary insurance. However, we are only able to do so if all information is provided by you, the patient. If all information is not provided or we are unable to verify eligibility, you will be responsible for the balance.

PRIMARY INSURANCE

Subscriber's Name _____

Date of Birth _____ () M () F

Employer _____

Phone () _____

Relationship to patient:

() Self () Spouse () Parent () Other

Insurance Name _____

Contract Number _____

Group Number _____

PCP (If an HMO Insurance) _____

SECONDARY INSURANCE

Subscriber's Name _____

Date of Birth _____ () M () F

Employer _____

Phone () _____

Relationship to patient:

() Self () Spouse () Parent () Other

Insurance Name _____

Contract Number _____

Group Number _____

PCP (If an HMO Insurance) _____

PLEASE PROVIDE OFFICE STAFF WITH YOUR INSURANCE CARDS TO OBTAIN COPIES FOR YOUR RECORDS.

RELEASE OF RELATED MEDICAL RECORDS

I authorize the release of my medical information needed to determine payment for services rendered. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges should they not be covered by my insurance company.

Signature _____ Date _____
(of patient or guardian)

PATIENTS WITHOUT INSURANCE COVERAGE

If you are a cash patient without insurance, you will be required to pay for your office visit prior to seeing the physician. If other services are needed (blood work, x-rays, etc.) payment in full is expected at the time of service.

We accept payment in the form of cash or credit cards. Checks will only be accepted for insurance co-pay payments from established patients (excluding Medicaid).

Signature _____ Date _____
(of patient or guardian)

Dr. Gregory Gould

Doctor
60005 Campground Suite 600

Address
Washington, MI 48094

Address
586-872-3500

Phone

ADULT HEALTH HISTORY

Date _____

Name _____

Date of birth _____

Age _____

General health _____

Are you currently or have you ever been treated for

Yes	No	Condition	Explain
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	<input type="checkbox"/>	Ear/sinus	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	
<input type="checkbox"/>	<input type="checkbox"/>	Gastro-intestinal problems	
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	
<input type="checkbox"/>	<input type="checkbox"/>	Learning disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems	
<input type="checkbox"/>	<input type="checkbox"/>	Musculo-skeletal	
<input type="checkbox"/>	<input type="checkbox"/>	Psychological/psychiatric	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	
<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease	
<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorders	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	
<input type="checkbox"/>	<input type="checkbox"/>	Surgery	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	
<input type="checkbox"/>	<input type="checkbox"/>	Serious injury	
<input type="checkbox"/>	<input type="checkbox"/>	Other	

List all medications you are currently taking, include over-the-counter drugs and herbal supplements

Medication	Dosage	Reason

Allergies

--

Signature _____

Health Risk Assessment Form

General

Name: _____ Gender: _____
 DOB: _____ Height: _____ Weight: _____
 Race: _____

Medical History

Date of last check-up: _____
 Allergies: _____
 Medications: _____
 Previous Medications: _____
 Injuries: _____
 Surgeries: _____
 Blood Pressure: _____
 Cholesterol: _____

History of...

Cancer: Me Relation: _____
 Diabetes: Me Relation: _____
 Stroke: Me Relation: _____
 Heart Disease: Me Relation: _____
 Heart Attack: Me Relation: _____
 Depression: Me Relation: _____
 Bipolar Disorder: Me Relation: _____

Females

Last date of most recent cycle: _____
 Date of last PAP Smear: _____
 Date of last breast exam: _____
 Date of last rectal exam: _____
 Year of last pregnancy: _____
 Did the pregnancy come to term? Yes No

Males

Date of last prostate exam: _____

Well-Being

Rate your overall well-being: Great Good Fair
 Poor Bad

Rate your health: Great Good Fair Poor
 Bad

How safe do you feel? Very Not Very Not at all

How satisfied are you with your life? Very Not Very Not at all

How often do you feel depressed? Always Often
 Occasionally Never

Current therapist: _____

Frequency of sessions: _____

Starting date: _____

Nutrition

How many daily servings of vegetables do you eat? None 1-2 3-4
 5-6 More

How many daily servings of fruit do you eat? None 1-2 3-4
 5-6 More

How many daily servings of grains do you eat? None 1-2 3-4
 5-6 More

How many daily servings of meat do you eat? None 1-2 3-4
 5-6 More

How many daily servings of sugar/carbs do you eat? None 1-2 3-4
 5-6 More

Drug Use

How often do you smoke tobacco? Never Occasionally
 Often Daily Used to

How often do you chew tobacco? Never Occasionally
 Often Daily Used to

When did the tobacco use start? _____

How many cigarettes do you have per day? _____

How many alcoholic drinks do you have per week? _____

How often do you binge drink Occasionally Weekly
 (5+ drinks in 1 hour)? Daily Never

Have you ever been treated for alcoholism? _____

How often do you black out/lose time? _____

Have you ever used recreational drugs? _____

Which drugs? _____

Have you ever abused prescription drugs? _____

Which drugs? _____

Have you ever been treated for drug use? _____

How often do you use Daily Weekly Often
 recreational drugs? Occasionally Rarely Never

Exercise

How many days per week do you work on cardio? _____

Length of time spent on cardio each session: _____

How many days per week do you work on strength? _____

Length of time spent on strength each session: _____

Injuries/conditions that interfere with exercise: _____

Other

Volunteer Activities: _____

Who do you live with? _____

Do you require...? Hearing Aid Walker Cane
 Oxygen Tank Glasses

How often do you get headaches? _____

Food Sensitivities: _____

How many hours of sleep do you get per night? _____

How restful is your sleep? Restful I wake up once or twice
 I wake up often Fitful

DR. GREGORY GOULD D.O. P.C.
PATIENT DEMOGRAPHICS & CONSENT TO TREATMENT

Name _____	First _____	M.I. _____	Last _____
Address _____	City _____	State _____	Zip _____
Home Phone () _____	Cell Phone () _____		
Can we leave a message at your home or on your cell phone? () Yes () No			
Date of Birth _____	() Male () Female	SS# _____	
Employer _____	Phone _____		
Marital Status () Single () Married () Divorced () Widowed	Date of Birth _____		
Spouse Name _____			
Employer _____	Phone () _____		
Can we contact your work? () Yes () No			

Emergency Contact (Someone not living in the home)

Name _____	First _____	M.I. _____	Last _____
Home Phone () _____	Cell Phone () _____		
Relationship to Patient? _____			

Parent or Guardian (Complete this portion if the patient is a minor under the age of 18)

Name _____	First _____	M.I. _____	Last _____
Date of Birth _____	SS# _____	Relationship _____	
() Contact Information Same as Listed Above			
Address _____	City _____	State _____	Zip _____
Contact Number _____			
Child Lives With () Mother () Father () Both () Step-Parent () Other _____			

Payment Is Due At The Time Of Service

Consent to Treat: I authorize and consent to the treatment deemed necessary by the Physician for myself (or my child). **Assignment of Benefits:** I authorize payment of benefits to Dr. Gould's Office for the services rendered to me (or my child). I understand I am responsible for any costs not covered under my insurance plan. **No Guarantee of Results of Care & Clinic's Termination Rights:** I agree no one has promised or guaranteed any results of my (or my child's) medical care. I agree that nothing in this form prevents Dr. Gould's Office from terminating my (or my child's) care with appropriate notice having been made.

Signature: _____ **Date:** _____

These questions are about your race, ethnicity, and primary language. We ask these questions to make sure we are meeting the needs of all of our patients. May I continue?

1. Are you of Hispanic or Latino origin?

- | | |
|-----|----------------------|
| No | Do not know |
| Yes | Unavailable |
| | Prefer not to answer |

2. What is your race? (You may select up to two races)

- | | | |
|-------|----------------------------------|----------------------|
| Black | Native Hawaiian/Pacific Islander | Do not know |
| White | American Indian/Alaskan Native | Unavailable |
| Asian | Other | Prefer not to answer |

3. Please provide one nationality or ethnic group that best describes your ancestry. (For example, Italian, Jamaican, African American, Haitian, Korean, Lebanese, etc.) (Please select one)

- | | | |
|----------------------|---------------|-------|
| Hispanic/Latino | Arab/American | Other |
| Do not know | | |
| Prefer not to answer | | |
| Unavailable | | |

4. What language do you feel most comfortable using when discussing your health care?

- | | | | |
|------------------------|----------|------|----------------------|
| American Sign Language | Hindi | Urdu | Other (specify) |
| Arabic | Hmong | | Do not know |
| Chinese | Japanese | | Unavailable |
| English | Spanish | | Prefer not to answer |

Name: _____

Date: _____

Please return this form to the representative.