



CORNERSTONE
WOMEN'S HEALTHCARE

MICHAEL D. ANDERSEN, M.D. ,FACOG
Cornerstone Women's Healthcare
Board Certified Obstetrician and Gynecologist
40700 California Oaks Rd. #205
Murrieta, CA 92562
Phone: (951)894-7555, Fax: (951)894-7575

Dear Valued Patient,

WELCOME! Thank you for choosing us for your OB/GYN care. We are committed to your healthcare, offering personalized service to our patients and families. Our patients are important to our practice, and we appreciate and value your time.

As an obstetrician, Dr. Andersen is committed to the highest level of care for you and your baby, offering quality care, gentle compassion, and a wealth of experience during this very special time in your life.

As a solo practitioner, Dr. Andersen is there for 99,9% of his OB deliveries. His patients will not have another physician arrive to deliver their baby or visit them after a procedure.

He is on call 24 hours - 7 days a week for his patients.

As a gynecologist, Dr. Andersen is experienced in providing healthcare to women of all ages, of all backgrounds. Providing guidance and understanding for your gynecological care, providing compassion and kindness for your concerns and questions.

As a surgeon, Dr. Andersen possesses the highest degree of skill in operating room, complimented by his bedside manner. He continues to pursue a higher level of understanding by enrolment in Continued Medical Education programs, relating to Women's Healthcare needs.

As a Laser Skin Specialist, Dr. Andersen is dedicated to the needs of our patients experiencing various medical conditions resulting in unwanted hair growth, varicose veins and cellulite. Clinically providing these services in a Medical Office setting. Ask our nurse about consultations for Cosmetic or Medical Laser Hair Removal, Laser Treatment of Varicose Veins and now Laser Cellulite Reduction.

As a Doctor, Dr. Andersen understands your concerns regarding your medical care, he is here to assist you in making accurate choices for your long term health care.

You are in good, gentle and caring hands.

**Please Note: Dr. Andersen would greatly appreciate the adorable pictures of your baby posted on his website www.michaelandersenmd.com and/or on his Facebook page [Michael Andersen, MD. Obstetrics and Gynecology](#)



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AUTHORIZATION TO LEAVE MESSAGES

Which phone number are you most likely to be available at during the day?

Home: _____

Cell: _____

Work: _____

CIRCLE ONE OR MORE

May we leave a message on your voice mail at: HOME WORK CELL
regarding normal lab results? YES NO

May we leave a message on your voice mail at: HOME WORK CELL
regarding appointments? YES NO

May we inform a family member, relative, partner, or friend you designate (you do not need to designate anyone) of your lab results, ultrasound, radiological screening and/or appointment?
YES NO

Name: _____ Phone#: _____

Patient Signature: _____ Date: _____



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FEES AND PAYMENT

Physicians share the concerns of their patients about the increasing cost of medical care. Our fees are within the customary range of this area and reflect the high level of care you will receive. We have standardized charges for various procedures but these vary depending upon unforeseen circumstances that might arise. These fees are listed in the office and are available to you at all times.

The fees for obstetrical care include: all routine visits, delivery, and the six-week visit following delivery. There are extra charges for lab tests, ultrasounds, non-stress tests (NST's), circumcisions, other special procedures, medical forms and letters, emergency visits to hospital. ante-partum visits in hospital beyond 7 days. If cesarean birth is necessary, an extra charge will be made for the surgery. In some instances involving hospital policies, the hospital may refuse us in scheduling surgery until insurance deductibles are settled. A processing fee is charged for some disability forms and copying records. **MEDICAL FEES ARE DUE AND PAYABLE AT THE TIME THE SERVICE IS RENDERED.** We accept payment by cash, ATM, or credit card. If you find it necessary to make financial arrangement please contact Susan Ford in our billing department at (951)694-6102.

PPO INSURANCE

If you are a member of a Preferred Provider Organization (PPO) and our office has signed a contract to provide services for your PPO, we will be happy to bill your insurance company. **YOU MUST PROVIDE US WITH A CURRENT COPY OF YOUR INSURANCE CARD AT THE TIME OF YOUR VISIT.** *Co-payments are required at the time of service.* Please be aware that due to specific policies in insurance contracts, most lab work and ultrasounds are done outside our office in order to be covered.

HMO INSURANCE

If you are a member of a Health Maintenance Organization (HMO) and our office has signed a contract to provide services for your HMO, we will bill your insurance for services rendered. Please be aware that due to specific policies in insurance contracts, most lab work and ultrasounds are done outside our office in order to be covered benefit.

ASSIGNMENT OF BENEFITS POLICY

I have read the above and understood that my insurance contract is between my insurance company and myself. Although Michael D. Andersen M.D., P.C. will be billing my insurance company, I understood that I am responsible for all charges including any charges considered over and above customary, if any deductible is indicated to be my responsibility for services rendered and will be due and payable upon receipt of any explanation of benefits supplied by my insurance company. ***I also understand that I will pay my Co-Payment, Co-Insurance or remaining deductible at the time of visit and that is my responsibility to provide authorization when applicable.***

I hereby authorize payments to be made direct to: **Michael D. Andersen, M.D.**

Signature of Patient

Print Patient Name

Date



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Dear Patient,

We feel it is important that you receive all laboratory results including blood work, Pap smears, mammograms, etc.... It is standard procedure for our office to notify our patients, by either phone or mail, of their results. However, in the unlikely event that your lab result is not received in our office(due to delivery, computer or fax error.) then the standard procedure, of notifying our patients will not take place. We ask you to share in the responsibility of obtaining your lab results by calling us for results if you have not been notified after a reasonable time period.

*Thirty (30) days for Pap smear and mammogram.

*Two (2) weeks for biopsy results.

*Seven (7) days for culture results.

*Two (2) weeks for routine lab work

*Twenty-four (24) to forty-eight (48) hours for all STAT or emergent lab work.

Please note: Radiology or Ultrasound technicians may promise same day results. They may not realize that studies must be read by the Radiologist and these results may not be readily available. Dr. Andersen, our Nurse Practitioner or our Nurse, will let you know during your visit what testing will be done so that you are aware of what results are pending.

I have read the above and I understand my responsibility.

Patient

Signature: _____ Date: _____

Please Print your Name: _____



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Healthcare Questionnaire

Today's Date: : _____ Reason for Visit: _____

Last Name, First Name: _____ Date of Birth: _____

List of Medications: 1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____ 7. _____

List of any Allergies: 1. _____ 2. _____ 3. _____

How many times have you been pregnant?: _____ Any pregnancy complications?: _____

How many children?: _____ How many miscarriages?: _____ How many abortions?: _____

Do you have any medical conditions?: Diabetes High Blood Pressure Asthma Coronary Artery Disease

Pregnancy History: Monty/Year Weeks Delivery Type Birth Weight Full-Term/Premature

1. _____
2. _____
3. _____
4. _____

Gynecological History:

Onset of Menses? (age period started) _____ How many days between cycles?(normal is 28 days) _____

How many days do you bleed? _____ What was the first day of your last menstrual cycle? _____

Any recent changes with cycles? _____

When was your last: Pap Smear? _____ Where was your last pap if not with us? _____

Mammogram? _____ Dexa Scan? _____

Have you ever had an abnormal Pap Smear? _____ When? _____ Sexual transmitted disease? _____

Have you ever had Pelvic Inflammatory Disease? _____ Do you leak urine? _____

Abnormal Mammogram? _____ Year: _____ Is Intercourse painful? _____ Do you bleed after intercourse? _____ How many sexual partners? _____ How many in the last 6 months? _____

Surgical History: Type of surgery Month/Year Facility Complications

1. _____
2. _____
3. _____

Do you smoke? _____ How many per day? _____ Do you drink alcohol? _____ How many per day? _____

Do you or a family member have the following? If yes, please label "P" for Paternal side or "M" for Maternal side:

High Blood Pressure: _____ Heart Disease: _____ Diabetes: _____ Cancer: _____

Breast Cancer: _____ Ovarian/Uterine Cancer: _____ Birth Defects: _____



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PATIENT INFORMATION

Patient's Full Name: _____

Date of Birth: _____ Age: _____ Social Security #: _____ - _____ - _____

Address: _____ City: _____ ZIP: _____

Phone #s (Home): _____ (Cell): _____ (Work): _____

Sex [M/F]: _____ Marital Status: S M D W Driver's Lic.#: _____

Name of Spouse/Significant Other: _____

Any known drug allergies?: _____

Who may we thank for referring you?: _____

Insurance Information

Insurance Company Name: _____ HMO or PPO

Subscriber Name: _____

Group #: _____ ID#: _____ SS#: _____

Employer: _____ Subscribers Date of Birth: _____

Emergency Contact Information

Name: _____ Address: _____

Phone: _____ Relationship: _____

Authorization for treatment of Minor

I authorize treatment for my child if brought in by someone else, in such case as I am unable to bring the child personally.

Authorization for treatment and Financial Agreement

I authorize treatment of the undesigned by Cornerstone Women's Healthcare and agree to pay all fees and charges for such treatment. I understand that I am responsible for these charges, even when covered by insurance, and that payment is expected at the time of service, unless credit arrangements are agreed upon beforehand. In the event legal action becomes necessary to collect an unpaid balance, I agree to pay reasonable attorney's fees and other such costs, as the court.

Assignment of Insurance Benefits

I hereby assign all medical benefits to which I am entitled, including Medicare, Champus, Private and other health plans to Cornerstone Women's Healthcare, and authorize him to release any information necessary to secure such payment. This assignment will remain in effect until revoked by me in writing and a photocopy of this assignment is to be considered as a valid as the original.

Signature: _____ **Date:** _____



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To Our Medi-Cal / IEHP Patients:

Please be informed that as of May, 2009 there will be a **\$25.00 fee** for the preparation and copying of all Medical Disability Form by Dr. Michael Andersen and staff.

We have been informed by Medi-Cal that the fee for this service will not be covered by Medi-Cal. Should you find yourself in need of this service payment must be received prior to the completion of these forms.

I have read and understand that the **\$25.00 fee** I have paid is for the preparation and copying of Medical Disability forms related to the condition for which Dr. Michael Andersen is treating me. This fee is not for any of the medical treatment I have received from any member of his office staff.

Patient Signature: _____ Date: _____

Patient Name (Print): _____