MICHAEL D. ANDERSEN, M.D. ,FACOG
Cornerstone Women's Healthcare
Board Certified Obstetrician and Gynecologist
24619 Washington Ave, Suite 104
Murrieta, CA 92562
Phone: (951)894-7555, Fax: (951)894-7575

Dear Valued Patient,

WELCOME! Thank you for choosing us for your Obstetrics and Gynecological 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% 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 and 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 the operating room, complimented by his bedside manner. He continues to pursue a higher level of understanding by enrollment in Continued Medical Education programs, relating to Women's Healthcare needs.

As a Board Certified physician, Dr. Andersen understands your concerns regarding your medical care and he is here to assist you in making the best and most accurate choices for your long term health care.

Visit us at our website: *drandersenobgyn.com*

You are in good, gentle and caring hands.

Thank you,

Dr. Michael Andersen & Staff

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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 Signture:___________________________________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.

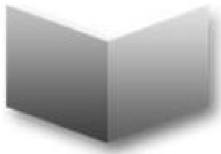
*Thirty (30) days for Pap smear and mammogram.
*Seven (7) days for culture results.
*Two (2) weeks for biopsy results.
*Two (2) weeks for routine lab work
*Twenty-four (24) to forty-eight (48) hours for all STAT or emergent lab work.

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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YEARLY HEALTH QUESTIONNAIRE

Today's Date:_________ Patient Name:___________________________ Date of Birth: ___________

Reason for visit: ____

❏ Mark here if you would like to add an STD Panel to your visit. **Please note this service may or may not be covered by your insurance under your Well-Woman Exam / Routine Check-Up*

Pharmacy Info Name: _____________________________Phone Number:_______________________

Pregnancy History:

Full-Term Deliveries (≥37 weeks): ________ Premature Deliveries (≤ 36 weeks): _________

Abortions: ________ Miscarriages: ________ **Total Number of ALL Pregnancies: ________**

Pregnancy Complication Notes: ____

Gynecological History:

First day of last period:_________________ How many days do you bleed? _______________

Number of days between cycles (Note: "normal" is every 28 days): ______________________

When was your last Pap Smear?_________________ Last Mammogram?_________________

Medication List :__________________________ Birth Control Method:__________________

Surgical History: Type of surgery Month/Year Facility Complications?

1.____

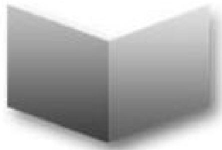
2.____

Personal History: (Mark all that apply.)

- ❏ Heavy Bleeding/Clotting with Periods
- ❏ Medication Allergy (Specify Here: _______________________________________)
- ❏ Complications with Pregnancy
- ❏ Abnormal Pap Smear (Year: ________)
- ❏ Sexually Transmitted Disease (Year: ________)
- ❏ Pelvic Inflammatory Disease (Year Diagnosed: ________)
- ❏ Leak Urine
- ❏ Abnormal Mammogram (Year: ________)
- ❏ Painful Intercourse
- ❏ Bleeding after Intercourse
- ❏ Sexual Partners (# in last month______)
- ❏ Current Smoker (# per day ______)
- ❏ Alcoholic Drinks (# per week ______)
- ❏ Family History of Medical Conditions: (ie. breast, ovarian, uterine cancer) (list below)

____

____



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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:____________________________Adress:___________________________________

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):____