Michael L. Mawby, MD
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231.935.0550
(Form revised 1/11/16)

Annual Update Form

Last Name: _____ First Name: _____ Middle Name: _____

Prefer to be called (Example: "Pat" for Patricia): _____

Social Security #: _____ DOB: _____ Age: _____ Gender: M F

Street Address: _____ City: _____ State: _____ Zip: _____

Billing Address (if different): _____ County: _____

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

Contact Preference (check one): ☐Pt. Portal ☐Home ☐Cell ☐Work ☐Other (please List #) _____

Email Address: _____

Race: _____ ☐ Prefer not to disclose

Preferred Language: _____ ☐ Prefer not to disclose

Ethnicity (Check one): ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐Unknown/Prefer not to disclose

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Are you a student? ☐ Full Time ☐ Part Time ☐ Not a student

Primary Care Doctor (PCP): _____

PCP Phone # (if new or changed): _____

Do you have any new insurance? ☐ No ☐ Yes (if yes, please present new cards to front desk)

Are you enrolled in Medicaid? ☐ No ☐ Yes (We are not able to see pts with Medicaid)

I understand that Arthritis & Osteoporosis Center (AOC) is not able to see patients enrolled in any Medicaid plan. I understand that it is my responsibility to advise AOC if I am currently or newly enrolled in Medicaid. I also understand that should I enroll in a Medicaid plan, I will need to seek rheumatologic services through a different provider.

Office Policies for Arthritis and Osteoporosis Center

All patients are requested to arrive 20 (twenty) minutes prior to their appointment time. Patients who arrive late may have to be rescheduled to the next available appointment time. When your appointments are scheduled you are given the "arrival time".

AOC requests that you speak directly to a staff member by noon two days prior to your scheduled appointment if you need to reschedule. If you are unable to do this you may be charged $45.00.

We will submit claims to your insurance company. However, the patient is responsible for any co-pays, deductibles or non-covered services at the time of service. The patient will be responsible for any insurance claims not paid after 90 (ninety) days from the date of service.

All checks returned for non-sufficient funds will have a $35.00 fee.

All prescription refills will be done at your appointment time. Refills needed outside of a scheduled appointment may require an additional appointment. Otherwise, please allow 3 (three) business days for refills. This office does not fax prescriptions.
Some requests for copies of medical records will be charged a fee. Please ask the front desk staff for an estimate. Allow 10-14 business days for completion.
Completion of forms or letters may have applicable charges. Please inquire at front desk for applicable charges. An office visit may be required for completion of forms.

Dr. Mawby does not determine disability and currently does not accept or bill Workers Compensation.

Dr. Mawby does not provide hospital in-patient services. If you are admitted to the hospital he can provide information/records to your admitting physician.

All sales of supplements or other products are final. AOC will not accept returns, and will not issue a refund.
These policies may change at any time without notice.

Authorization

I authorize the office staff of Dr. Mawby's to discuss my treatment plan with the following people if they call the office with questions on my behalf. ☐ YES ☐ NO

_____	_____	(___)_____
Name	relationship	phone
_____	_____	(___)_____
Name	relationship	phone

Consent for Medical Treatment

I authorize AOC providers and personnel to render medical evaluation and treatment if needed for this appointment and all future appointments.

Notice of Privacy Practices & Signature

AOC's Notice of Privacy Practices describes the specific meaning of "treatment", "payment", "health care operations" and how AOC may use and disclose my health information to carry out these functions. AOC has a copy posted in the waiting room and a copy available upon request or you may access the document online at www.aoctc.com.

Signature of Patient or Responsible Party _____ **Date:** _____

Revised 6/2015