PROVIDENCE GASTROENTEROLOGY

Phone (248) 662-4110 | Fax (248) 662-4120
26850 Providence Parkway, Suite 350, Novi, MI 48374

PATIENT INFORMATION- Please verify all information in the spaces provided

Last Name: _____ First: _____ MI: ___ (use Driver's License name only)

Address: _____ City, _____ MI, Zip _____

Sex: _____ Cell: _____ Home Phone: _____ Work Phone: _____

DOB: _____ SSN: _____ Marital Status: _____ Legal Guardian: ☐ Yes ☐ N/A

Email: _____ **Race:** ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic **Language:** ☐ English ☐ Japanese ☐ Russian ☐ Other _____

INSURANCE- Receptionist will copy/scan driver's license and insurance cards at time of visit.

Primary Insurance: _____ Phone #: _____ Effective: _____
ID#: _____ Group: _____ Pre-Auth #: _____

Insured Name: _____ DOB: _____ SSN: _____ Copay: _____
☐ Retired ☐ Full Time ☐ Part Time Employer Name: _____

Employer Address: _____ Occupation: _____

Secondary Insurance: _____ Phone #: _____ ID#: _____ Group: _____ Pre-Auth #: _____
Insured Name: _____ DOB: _____ SSN: _____ Copay: _____

PRIMARY CARE / INTERNAL MEDICINE PHYSICIAN

Name: _____ **Phone**: _____ **Fax**: _____
I hereby give my permission to my doctor to release medical information to my referring physician.

EMERGENCY CONTACT

Name: _____ Daytime Phone: _____

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CARDIAC INFORMATION

Full name of Cardiologist: _____ Phone: _____ Fax: _____

YES	NO	PLEASE **correctly ANSWER** YES OR NO: ****IMPORTANT personal HISTORY****
		IN THE LAST 3 MONTHS have you had a **Heart Attack, Stroke, or Congestive heart Failure**? (If yes, BOARD @ HOSPITAL)
		Do you have an **Implanted Cardiac Defibrillator** or **Pacemaker**? (If yes, BOARD @ HOSPITAL)
		Do you weigh **over 350 pounds**? (If yes, BOARD @ HOSPITAL)
		Do you **use oxygen** or **C-PAP** machine at home? (IF PT USES ANY OXYGEN, BOARD @ HOSPITAL)
		Are you on **dialysis**? (If yes, BOARD @ HOSPITAL)
		Do you use a wheelchair? If yes, ask; can you transfer yourself to a bed without assistance? (If No to 2nd ?, BOARD @ HOSPITAL)
		Have you or any family member had **problems with anesthesia** in the past?
		Do you see a heart doctor on a regular basis? (Reason) ***need cardiologist name above***
		Do you experience **chest pain at rest**? Do you experience chest pain **unrelieved by Nitroglycerin** tablets?
		Are you **taking diet pills**, not limited to but **including Phen-Phen or Phentermine**? (**Stop 2 weeks before** any elective **surgery**)

I hereby authorize payment of medical benefits billed to my insurance to my doctor. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I authorize the release of pertinent medical information needed to determine benefits for related services to insurance companies and their agents. I agree to pay all co-payments for office visits at the time the service. I will pay by cash, check, Visa or Master Card.

X_____ Date: _____

Signature of patient or guardian

PATIENT HEALTH INFORMATION PRIVACY PROTECTION ACT FORM

HIPPA NOTICE OF PRIVACY PRACTICES RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS CONCENT

I, _____hereby authorize my doctor to use and/or disclose my health information which specifically identifies me, or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, my gastroenterologist can refuse to treat me.

I have been informed that my doctor has prepared a notice ("NOTICE") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

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For Patient Centered Medical Home and other insurance programs, we are required to forward all testing and office notes to your Primary Care Physician for coordination of your care and to avoid any repeated testing.

I understand that I may revoke this consent at any time by notifying my doctor in writing, but if I revoke my consent, such revocation will not affect any actions that my doctor took before receiving my revocation.

I understand that my doctor has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that my doctor restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations, but that once such restrictions are agreed to, my doctor must adhere to such restrictions.

X_____ Date: _____
Signature of patient or guardian

Date of birth: _____

Release of Prescription History

I grant consent to view my prescription history from external sources:_____approved or _____denied.

X_____ Date: _____
Signature of patient or guardian

Phone Message Consent

From time to time, it may be necessary or desirable to contact patients by phone. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible.
I give permission to leave relevant medical information on my answering machine or voice mail on my main phone or cell phone number listed under patient information.

X_____ Date: _____
Signature of patient or guardian

HEALTH INSURANCE DISCLOSURE INFORMATION FORM

Please check off and fill out all information in the spaces provided.

Reason for today's visit:

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☐ Routine Preventive Exam (I have no medical complaint or significant problem/abnormality that I am aware of)

☐ I have a problem/complaint that I wish to have evaluated/treated by the doctor.
My appointment chief complaint is: _____

INSURANCE COVERAGE, BENEFITS AND AUTHORIZATION

I hereby authorize payment of medical benefits billed to my insurance to my doctor. I authorize the release of pertinent medical information needed to determine my benefits for related services to insurance companies and their agents. This office will file a claim on my behalf; however, if my insurance company refuses to pay, for whatever reason, I will pay for same upon written/verbal notice of their refusal. Doctors Greer, Sorser and Physician Assistants Rachelle Packey and Susan Wosik, billing is completed by office billers. Dr. DeVore, Ngo, Piper and Warren's billing is completed by Premier Billing Company.

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical record. Thus, to ask this office to change a diagnosis code solely for the purpose of securing reimbursement from any insurance carrier is inappropriate and may result in a fraudulent act(s).

I hereby accept responsibility for payment for any service(s) provided to me that is not covered, not a benefit under my insurance plan, for whatever reason (e.g., non-covered services, does not pay for preventive medicine visits, my failure to secure a referral from my primary care physician). I also accept responsibility for fees that exceed the payment made by my insurance if the Practice does not participate with my insurance. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.

If I get orders for follow up services, I will be responsible to contact my insurance company to verify my coverage and benefits. I will also check with my insurance to see if I need an authorization for services. I will notify the office well in advance if needed.

Our policy is to collect any unpaid balances and office copays at the time of check-in. My current account balance is _____. I agree to pay all co-payments for office visits at the time of the service. If my co-payment is not paid, I agree to be charged the additional processing expenses. A $10.00 service fee monthly for mailing invoices and processing may be charged to my account over and above my normal co-payment. In the event I do not pay for these, or any other services provided to me when due, I agree to pay all costs of collection, including reasonable attorney fees, whether or not a lawsuit is commenced as part of the collection process.

X_____ Date: _____
Signature
Date of birth: _____

X_____
Signature of witness

PATIENT SPECIALIST PARTNERSHIP AGREEMENT

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As a part of your Patient-Centered Medical Home Neighborhood, we welcome you to our Specialty Practice!

We are partnering with your Primary Care Physician (PCP) who is your *Patient Centered Medical Home*. We share their commitment to effectively and efficiently working together to manage your care. As your Specialist, We will be sharing information about your condition and provide recommendations, guidance and periodic follow-up.

A Patient-Centered Medical Home - neighborhood (PCMH-n) is a system of care in which a team of health professionals work together to provide your entire healthcare needs. You, the patient, are the most important part of the PCMH-n. When you take an active role in your health and work closely with us, you can be sure that you're getting the care you need.

We trust you as our patient to:

- Make healthy decisions about your daily habits and lifestyle • Seek the advice of your PCP before you see other physicians.
- Tell us what medications you are taking. • See your PCP for all preventive services
- Keep your appointments as scheduled or call and let us know if you are unable to keep your appointment.
- Follow the care plan that is agreed upon-or let us know why you cannot follow the plan so we can try to help you.

As your Specialist I will:

- Communicate with your Primary Care Physician (PCP) and provide timely written reports.
- Notify your PCP of no-shows, cancellations and other actions that may place your care in jeopardy.
- Notify your PCP if you are being referred to another specialist
- Remind you of tests due and inform you of your test results
- End every visit with clear instructions about expectations, treatment goals, and how I will coordinate with your PCP

Coordination of care and communication back to your PCP is my priority. Should you have other physicians managing your care please inform them that I am the specialist managing your digestive (GI) condition and that I require communication regarding any treatment that may affect my treatment plan.

PRACTICE HOURS- Monday, Tuesday, Wednesday, Thursday, Friday (8:00 a.m. - 4:00 p.m.)

- Should you have an AFTER-HOURS issue please contact me for your digestive (GI) condition. For after-hour emergencies you can also call our answer service Perfect Serve at 866-830-7280. I will direct you with the next steps. If it is non-emergency and can be treated within an Urgent Care setting, I will refer you to Novi Urgent Care or an urgent care closer to your home.
- Should you have an issue not pertaining to my care, please contact your Primary Care Physician.
- Should you need a refill on a medication that I prescribed for you please contact my office during business hours, or just ask your pharmacy to send a request for a refill via e-prescribe, this type of request goes directly to me.

Ask any of our staff about Community Services or contact the following: NEED HELP? 2-1-1 is now available. Dial 211 from any phone and you will be connected with a referral hotline that can connect you with non-profit agencies in your area that can help with Human, Health and social needs (i.e., utilities, housing, health insurance, food, diapers, etc.) A listing of the area resources can also be found on this website: http://www.referweb.net/uwjc

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Please see the following page to sign up for our private Patient Web Portal.
We have a Patient Portal that supports two-way, secure and compliant communication. Thank you.

X_____ Date: _____
Signature of patient or guardian

PATIENT PORTAL AUTHORIZATION

X_____ Date: _____

Though Patient Centered Medical Home they have community service agencies that may be able to help in cases of need. Please fill out the information below if needed and we can forward the information.

☐ No need for community services

REQUEST FOR COMMUNITY SERVICES

Please check those services you feel you would benefit from or those on which you would like more information:

☐Transportation
☐Food (WIC, Meals on Wheels, Food Band)
☐Prescription Assistance
☐Private Hire Resources
☐Minor Home Repair and Chore Services
☐Respite Relief for Care Giver Support
☐Alzheimer's and Dementia Care Assistance
☐Other. Please provide details below:
☐_____

☐_____

My name is _____

☐I prefer to be contacted by:

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☐Phone _____

☐e-mail _____

☐Mail _____

X_____ Date: _____

Signature of patient or guardian

Date of birth_____