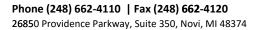


PA	TIENT INFORMATION	- Please verify all infor	mation in the space	es provided		
Last Name:	F	irst:	MI: _	(use Driver's L	icense nam	e only)
Address:		City,			MI,	Zip
Sex: Cell:		Home Phone	e:		Work	Phone:
DOB:	SSN:	Marital Stat	us: L	egal Guardian: 🗆	Yes □ N/A	Α
Email:		Race: Asian Blace	ck □ Hispanic □ WI	nite 🗆 Other		
	Not Hispanic Language: 🗆 Eng					
INSUR	ANCE- Receptionist will cop	by/scan driver's license	and insurance card	s at time of visit		
•	Crount					
1D#:	Group:			Pre-Aum #:		
	Part Time Employer Name:					
Employer Address:			Occup	ation:		
Secondary Insurance:		Pho	one #:			_ ID#:
	Group:			Pre-Auth #: I:		
	PRIMARY CARE / 1	INTERNAL MEDIC	CINE PHYSICIA	N		
				Fax:		
I hereby give my permission to my	doctor to release medical information to	my referring physician. ERGENCY CONTAG	CT			
	EMI	ERGENCI CONTAC	<u> </u>			
Name:		Daytime Phone:				



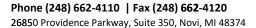


to treat me.

Full name YES NO	of Cardiologist: PLEASE correctly ANSWER YES OR NO: ****IN	Phone: Fax:
YES NO	•	
		MPORTANT personal HISTORY****
	IN THE LAST 3 MONTHS have you had a Heart Attack , Strok	e, 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 A	NY 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 is	n 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 ches	st pain unrelieved by Nitroglycerin tablets?
	Are you taking diet pills, not limited to but including Phen-Phe	en or Phentermine? (Stop 2 weeks before any elective surgery)
release of pertinent		by my insurance, if the Practice does not participate with my insurance. I authorize the principal insurance companies and their agents. I agree to pay all co-payments for office visits
X		Date:
Signature of J	patient or guardian	
	PATIENT HEALTH INFORMATION P	RIVACY PROTECTION ACT FORM
HIPPA 1	NOTICE OF PRIVACY PRACTICES RELE PAYMENT, AND HEALTH CAR	EASE OF INFORMATION FOR TREATMENT, RE OPERATIONS CONCENT
т	hereby author	ize my doctor to use and/or disclose my health information
1,	IICICOV autiloi	

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.





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:
X	
Date	ate of birth:
Release of Prescri	cription History
I grant consent to view my prescription history from external sources	ces:approved ordenied.
X	Date:
XSignature of patient or guardian	
Phone Message	ige Consent
From time to time, it may be necessary or desirable to contact patien	
of convenience, if you are not available to speak with us directly, we	· · · · · · · · · · · · · · · · · · ·
I give permission to leave relevant medical information on my answer number listed under patient information.	vering 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 DISCLOSU	LIRE INFORMATION FORM
TIE/LETT INSOLVANCE DISCLOSUI	OIL IN OIL MONTON

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

Reason for today's visit:





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 me information needed to determine my benefits for related services to insurance companies and their agents. This office will ficalim 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 completed by office billers. Dr. DeVore, Ngo, Piper and Warren's billing is completed by Premier Billing Company.	le a
I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis the encountered and documented in my medical record. Thus, to ask this office to change a diagnosis code solely for the purp 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, from my primary care physician). I also accept responsibility for fees that exceed the payment made by my insurance Practice does not payticipate with my insurance. Failure to pay within 45 days of filing is, for the purpose of this agreement refusal to pay.	eferral if the
If I get orders for follow up services, I will be responsible to contact my insurance company to verify my coverage and ber will also check with my insurance to see if I need an authorization for services. I will notify the office well in advance if need	
Our policy is to collect any unpaid balances and office copays at the time of check-in. My current account bala 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 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 when due, I agree to pay all costs of collection, including reasonable attorney fees, whether or not a lawsuit is commentated of the collection process.	e to be narged to me
X Date:	
Signature Date of birth:	
X	
Signature of witness	
PATIENT SPECIALIST PARTNERSHIP AGREEMENT	
PATIENT SPECIALIST PARTNERSHIP AGREEMENT	



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 <u>digestive (GI)</u> 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 <u>AFTER-HOURS</u> issue please contact me for your <u>digestive (GI)</u> condition. For after-hour emergencies you can also call our answer service <u>Perfect Serve at 866-830-7280</u>. 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/uwic





	Date.
Signature of patient or guardian	Date:
PATIENT PORTAL AUTHORIZATION	
X	Date:
9	y have community service agencies that may be able to help in case needed and we can forward the information.
☐ No need for community services	
REQUEST FOR COMMUNITY SERVICES	
Please check those services you feel you wo	ould 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	e
☐Other. Please provide details below:	
_	
Ц	



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

□Phone ____
□e-mail ____

□Mail ____

X_____ Date: ____
Signature of patient or guardian

Date of birth _____