

PROVIDENCE

GASTROENTEROLOGY

Designated Patient-Centered Specialty Practice

26850 Providence Parkway, Suite 350, Novi, MI 48374

22250 Providence Drive, Suite 703, Southfield, MI 48075

LAURENCE E. STAWICK, M.D., A.G.A.F.

MARK S. DeVORE, M.D., F.A.C.P.

JULIA S. GREER, M.D.

KHA H. NGO, D.O.

SERGE A. SORSER, M.D.

Phone (248) 662-4110 Fax (248) 662-4120

Phone (248) 569-1770 Fax (248) 443-2439

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: _____

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 2 nd ?, 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 Phenteramine? (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



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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.

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, _____ 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



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HEALTH INSURANCE DISCLOSURE INFORMATION FORM

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

My insurance plan covers Preventive Medical Services.

My insurance plan does not cover Preventive Medical Services.

I do not know if my insurance plan covers Preventive Medical Services

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 in 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 Stawick, Greer, Ngo & Sorser billing is completed by office billers. Dr. DeVore'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 for 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 the service. If my **co-payment is not paid**, I agree 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 me when due, I agree to pay all cost of collection, including reasonable attorney fees, whether or not a lawsuit is commenced as part of the collection process.

X _____
Signature of patient or guardian

Date: _____

Date of birth: _____

X _____
Signature of witness

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 are sharing their commitment to effectively and efficiently work 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 when 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 next steps. If it is non emergent 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/uwj>

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

Date of birth: _____



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PATIENT PORTAL AUTHORIZATION

Purpose of this Form: Dr. Mark S. DeVore, Dr. Julia S. Greer, Dr. Kha Ngo, Dr. Serge Sorser, Dr Laurence Stawick offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works: A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass- phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks: This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

- 1) the secure message must reach the correct email address, and
- 2) only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.**

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Types of Online Communication/Messaging:

Online communications should never be used for emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact your physician via telephone.

If there is information that you don't want transmitted via online communication, please inform your practice.

Patient Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

No e-mail Will not disclosed (not interested, don't want, too many e-mails, etc.)

Email address: _____

X _____ Date: _____
Signature of patient or guardian

Date of birth: _____



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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:

Phone _____

e-mail _____

Mail _____

X _____
Signature of patient or guardian

Date: _____

Date of birth: _____