MICHIGAN PRIMARY CARE PARTNERS
INTERNAL MEDICINE | FAMILY MEDICINE | PAIN MANAGEMENT

20095 Gilbert Road, Ste B
Big Rapids, MI 49307
Tel: (231) 592-4093
Fax: (231) 592-3421

4024 Park East Court SE, Ste C
Grand Rapids, MI 49546
Tel: (616) 975-1186
Fax: (616) 975-0467

Neil Goodman, DO
Board Certified Family Practice
Rashmi Juneja, MD
Board Certified Internal Medicine
Joseph Wolschleger, MD
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Catherine Balanda, NP
Monica DeLaney, PA-C
Melissa Kooistra, PA-C
Christopher Van Ryn, PA-C

Welcome to Michigan Primary Care Partners

We are committed to providing you with the best care in order to meet and exceed your health care needs. We hope to form a partnership to keep you as healthy as possible, no matter your current state of health.

Attached are a Health Care Questionnaire, New Patient Intake Form, Consent to Treat, Payment Policy, Authorization of Use & Disclosure of PHI (protected health information), Acknowledgement of Receipt of Notice of Privacy Practices, and Permission to Access Data from the information system at Mecosta County Medical Center.

At check-in you will be asked to show your insurance cards and your driver's license. We will make an electronic copy of each. Please be prepared each and every visit by bringing your insurance cards, as well as any co-pay, co-insurance, or deductible. Also, please bring the medications that you currently take in their original containers. We will make a notation of them in your medical record. During your visit you will meet our staff and your provider; you will have your height, weight, blood pressure, pulse, and respirations noted by a medical assistant. The provider will review your health questionnaire with you, and will provide you with a thorough examination. After the examination, your provider will suggest a treatment plan and future visits if necessary.

We hope that after your first visit you will feel confident with your decision of choosing our practice. We have multiple providers in multiple locations; you may be scheduled with any of them for future visits at the location of your choice. This will allow you to meet all of our providers, because there may be times when you cannot get in to see "your" provider due to scheduling reasons or emergencies. This will help you feel more comfortable with any provider in our practice. If you are not comfortable with one provider's practice style, you may schedule your next appointment with an alternate provider in our practice.

Again, welcome to Michigan Primary Care Partners, and thank you for choosing our practice for your health care needs.

Sincerely,

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PERMISSION TO ACCESS DATA FROM MECOSTA COUNTY MEDICAL CENTER'S INFORMATION SYSTEM

I hereby authorize **Michigan Primary Care Partners, PC d/b/a Medical Specialists** (or authorized staff) to obtain results of labs, x-rays, diagnostic tests, screening tests, reports, or other information that are available through the Medical Information System of Mecosta County Medical Center. I understand that this information will be used only for the diagnosis or treatment of the condition for which I am seeking care and that only those results pertinent to my diagnosis or treatment will be accessed. I also understand that demographic data may also be obtained to assist or billing or contacting me. I may revoke this agreement at any time by submitting a written request. I understand that this information may become part of my medical record in the Michigan Primary Care Partners, PC d/b/a Medical Specialists system.

_____ _____

Patient's Signature (or guardian) **Date**

Form #541.12.22.10

MPCP
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CONSENT TO TREAT

The term "health care provider(s)" in this document means Michigan Primary Care Partners, P.C., its employees, members of the medical staff and their employees, and other health care practitioners who provide care to patients.

I, _____ understand that as part of my health care,

this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plan of care including future treatment. I understand that this information serves as:

1. Basis for planning my treatment and care.
2. Information used to file a claim with my insurance company (procedure and diagnosis).
3. Means by which a third-party payer can verify that billed services were actually provided.
4. A tool for routine health care operations including assessing quality and reviewing competency of our staff and/or other health care providers.

I understand that I have been provided with the Notice of Information Practices that provides more complete information of uses and disclosures. I understand that I have the right to review the notice before signing the consent. I understand that the organization reserves the right to change its notice and practices, and prior to implementation will mail a copy of any revised notice to the address that I have provided. I understand that I have the right to restrict how my health care information may be used or disclosed to carry out payment, treatment, or health care operations and that the organization is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the organization has already taken action on my behalf.

Permission is hereby granted to all health care providers involved in my care to administer such examination, treatment, testing and procedures as are deemed necessary in the course of my care.

I have read and understand the above.

_____	_____	_____/_____/_____
Patient or Representative Signature	Relationship to Patient	Date

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PAYMENT POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable healthcare. Because some patients have questions regarding patient and insurance responsibility for services rendered, we have noted the following:

1. Insurance
We participate with most insurance plans, including Medicare, Blue Cross Blue Shield, and Priority Health. If you are not insured by a plan with which we participate, payment is expected at each visit. Knowing your insurance benefits is a patient's responsibility. Please contact your insurance company with any questions that you may have regarding coverage.

2. Co-payments and Deductibles
All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. Non-covered services
Please be aware that some of the services you may receive may not be covered or not considered reasonable or necessary by Medicare and other insurers. You must pay for these services.

4. Proof of insurance
All patients must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license and current valid insurance cards to provide proof of insurance. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission
We will submit your claim and assist you in any way that we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to do so.

I have read and understand the above.

_____	_____	_____/_____/_____
Patient or Representative Signature	Relationship to Patient	Date

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Assignment of Insurance Benefits

I hereby authorize payment to Michigan Primary Care Partners, P.C., (MPCP) the benefits payable to me, but not to exceed the balance of the charges for this event. All co-pays and deductibles are due prior to time of treatment. I agree the information presented on this form to be true and accurate.

Financial Responsibility

I understand that I am financially responsible to MPCP for any amount not covered by this authorization. The insurance policy is a contract between myself and my insurance company. A claim will be filed with my insurance carrier within 45 days. If payment is not made by the insurance carrier within 45 days of the filing, the balance will automatically transfer to the responsible party account. Payment by responsible party is expected within 10 business days of notice of insurance non-payment. In the event that this account is placed with an attorney or collection agency, the undersigned is responsible for collection fees, reasonable attorney's fees, and court costs.

Authorization

I hereby authorize release of my medical record information necessary to process insurance claims. I authorize MPCP to issue a complaint to the insurance commissioner for any reason. I further authorize the release of medical information to those healthcare facilities and/or physicians who may be responsible for my care. I understand that it may be necessary to test my blood to protect against possible transmission of blood-borne disease such as Hepatitis B or Acquired Immune Deficiency Syndrome (AIDS) if, for example, an employee or physician is struck by a needle or sustains a scalpel injury during the performance of care. I understand and consent that my blood as well as the employee's or physician's blood will be tested (as appropriate). I further understand that routinely tested blood results and tests for those diseases mentioned will be kept confidential in accordance with state law.

Note
Some services are provided and billed separately by independent agencies. You may receive billing from these agencies.

_____/_____/_____	_____	_____
Date	Signature (Patient or Legal Guardian)	Relationship to Patient

_____	_____
Responsible Party Social Security Number	Witness

Receipt of Privacy Notice

I acknowledge that I have received notification in regards to the Health Insurance Portability and Accountability Act (HIPAA) and have access to a copy of the written Joint Notice of Privacy Practices.

_____/_____/_____	_____	_____
Date	Signature (Patient or Legal Guardian)	Relationship to Patient

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NEW PATIENT INTAKE

____/____/_____ **Today's Date**

Last Name _____ **First Name** _____ **Middle Initial** _____

Date of Birth _____/_____/_____ **Age** _____ **Sex** M / F

DEMOGRAPHICAL INFORMATION

Address1	Address2	City	State Zip

Home Phone	Work Phone	Cell Phone	Social Security Number
(___)_____-_____	(___)_____-_____	(___)_____-_____	

Employer Name	Employer Address	Occupation	Driver's License Number

Allergies _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

EMERGENCY CONTACT

Name	Relationship	Emergency Phone
		(___)_____-_____

Address1	Address2	City	State Zip

INSURANCE INFORMATION

Primary Insurance Company	Address

Subscriber's Name	Subscriber's Social Security #	Subscriber's ID Number	Group or Local Number

Subscriber's Relationship to Patient: ☐ Self ☐ Spouse ☐ Other _____

Secondary Insurance Company	Address

Subscriber's Name	Subscriber's Social Security #	Subscriber's ID Number	Group or Local Number

Subscriber's Relationship to Patient: ☐ Self ☐ Spouse ☐ Other _____

INSURANCE AUTHORIZATIONS

I hereby authorize **Michigan Primary Care Partners, PC d/b/a Medical Specialists** to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

I hereby authorize direct payment of surgical/medical benefits to **Michigan Primary Care Partners, PC d/b/a Medical Specialists** for services rendered by them in person or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance.

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

Patient: _____ Date: _____

Parent/ Guardian: _____ Signature: _____

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MEDICAL HISTORY

Name _____ **Date of Birth** ____/____/_____ **Today's Date** ____/____/_____
Address _____ **SSN#** _____ **Occupation** _____
Phone (home) _____ **Phone** (work) _____
Chief Complaint _____

DRUG ALLERGIES

CURRENT MEDICATIONS

Women

☐ **Pregnant** ☐ **Planning pregnancy**

Men

It's common for men to occasionally experience erection difficulties. Is this something that happens to you?

☐ **Never** ☐ **Rarely** ☐ **Sometimes** ☐ **Frequently**

FAMILY HISTORY

	Father	Mother	Siblings	Children
Is Deceased?	☐	☐	☐	☐
Cause				
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐

MEDICAL HISTORY

☐ **Headache**	☐ **Pneumonia**	☐ **Venereal disease**	☐ **Scarlet fever**
☐ **Shortness of breath**	☐ **Ulcer**	☐ **Frequent infections**	☐ **Chronic rashes**
☐ **Heart palpitations**	☐ **GI disorder**	☐ **Hepatitis**	☐ **Rheumatic fever**
☐ **Heart murmur**	☐ **Lactose intolerance**	☐ **Anemia**	☐ **Measles**
☐ **Chest pain**	☐ **Gallbladder disease**	☐ **Arthritis**	☐ **Gout**
☐ **Dizziness/Fainting**	☐ **Prostate disease**	☐ **Osteoporosis**	☐ **Chronic rashes**
☐ **Allergies/Hay fever**	☐ **Bowel irregularity**	☐ **Depression**	☐ **Allergy/Hay fever**
☐ **Asthma**	☐ **Sexual/menstrual dysfunction**	☐ **Nervousness**	☐ **Bronchitis**
☐ **Incontinence**			

COMMENTS

HOSPITALIZATION OR SURGERY

Reason	Date

LIFESTYLE

Smoke: _____ Packs daily _____ How long? _____ Interested in stopping?
Coffee: _____ Cups daily _____ Other caffeine
Alcohol: _____ Type _____ Amount
Diet: _____ Salt intake _____ Fat intake
Sleep: □ Difficulty falling asleep □ Continuity disturbances □ Snoring
□ Early morning awakening □ Daytime drowsiness
Exercise:

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AUTHORIZATION OF USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

To: **Michigan Primary Care Partners, PC d/b/a Medical Specialists**

DOE	**JOHN**	**01/01/2008**
Patient Last	**Patient First**	**Date**

JOHN DOE

Patient Signature

_ONLY FILL OUT IF YOU ARE THE LEGAL GUARDIAN__

Patient Representative Signature **Patient Representative Relationship**

Persons/organizations to whom PHI may be disclosed:
EXAMPLES ~ JANE DOE ~ SPOUSE
SALLY SMITH ~ DAUGHTER

Information to be disclosed or used:
*** ANY OR ALL**

Purpose of disclosure:
*** CONTINUATION OF CARE**

This authorization is effective through *** LIFETIME**____/_____/_____ unless revoked or terminated earlier by the patient or the patient's representative. You may revoke this authorization by submitting a written revocation letter to **Michigan Primary Care Partners, PC d/b/a Medical Specialists**.

POTENTIAL FOR RE-DISCLOSURE: Information that is disclosed under this authorization may be disclosed again by the person/organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once we disclose it to another party.

EFFECT OF REFUSING AUTHORIZATION: If you refuse to sign this authorization, we will not deny you any treatment.

SAMPLE PAGE
*** MAY COPY THIS AREA**

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AUTHORIZATION OF USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

To: **Michigan Primary Care Partners, PC d/b/a Medical Specialists**

_____ _____ _____/_____/_____
Patient Last **Patient First** **Date**

_____
Patient Signature

_____ _____
Patient Representative Signature **Patient Representative Relationship**

Persons/organizations to whom PHI may be disclosed:

Information to be disclosed or used:

Purpose of disclosure:

This authorization is effective through _____/_____/_____ unless revoked or terminated earlier by the patient or the patient's representative. You may revoke this authorization by submitting a written revocation letter to **Michigan Primary Care Partners, PC d/b/a Medical Specialists**.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

Michigan Primary Care Partners, PC d/b/a Medical Specialists reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for **Michigan Primary Care Partners, PC d/b/a Medical Specialists**.

_____
Date

_____
Patient Name (Printed)

_____
Patient Signature

_____
Patient Representative Name (Printed)

_____
Patient Representative Signature
(required if the patient is a minor or an adult who is unable to sign this form)

_____
Patient Representative Relationship to Patient