MICHIGAN
PREMIER INTERNISTS
Division of Michigan Healthcare Professionals

Single____
Married____
Widowed____
Divorced____

Date_____

Name:_____Sex:_____Age:_____Birth Date:_____
(Last) (First) (Middle)

Address:_____
(#) (Street) (City) (State) (Zip)

Home Phone:_____Cell Phone:_____E-Mail:_____

Social Security:_____Insurance:_____Referred to Doctor by:_____

Patient's Occupation:_____If employed, by whom:_____Business Phone Number:_____

Spouse's Full Name:_____Phone:_____

Emergency Contact:_____Relation:_____Phone:_____

I certify that I, and/or my dependents, have insurance coverage with _____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services render. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above- named physician may use my health care information and may disclose such information to the above named insurance copay(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

To the extent permitted by the law, I authorize any holder of medical or other information about me to release to the centers for Medicare and Medicaid services, my Medigap insure and their agents any information needed to determine these benefits or benefit

Patient Signature:_____ Date:_____

Parent or Guardian Signature:_____ Date:_____

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Patient Care Assessment/History Form

Date_____

Name _____ Sex M/F D.O.B._____

Drug Allergies_____

Reason for Visit_____

Medical History

Illness	Patient		Family		Illness	Patient		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Heart Disease					Lung Disease				
Diabetes					Gastrointestinal				
High Blood Pressure					Seizures				
Kidney Problems					Mental Illness				
Cancer (Specify Below)					Stroke				
PPD					Blood Transfusion				

Specifics and Dates_____

_____

Other Health Issues not listed above_____

_____

_____

	Yes/No	
Tobacco	__ __	Daily Amount _____ x _____ years
Drugs	__ __	Type _____ Daily Amount _____
Alcohol	__ __	Type _____ Daily Amount _____

Hospitalizations/ER Visits/Surgeries/Procedures

When	Where	Why

Medications (including over the counter meds)

Name	Dosage	Instructions	Reason

Have you ever been rejected for health reasons by the military, an employer, or insurance company? __Yes __No

Were you sick, but failed to get medical care within the last year? __Yes __No

Did you miss more than ten days of usual activity last year due to illness? __Yes __No

General
___ Weakness
___ Fatigue
___ Chills
___ Night Sweats
___ Change in weight, appetite
Or sleeping habits

Skin
___ Itching
___ Rash
___ Change in color
___ Easy bruising

Nervous System
___ Headaches
___ Dizziness
___ Double vision
___ Muscle weakness
___ Numbness
___ Loss of coordination

Lungs
___ Cough
___ Wheezing
___ Shortness of breath
___ Spitting blood
___ Positive TB test
___ Last chest x-ray_____

Heart
___ Chest Pain
___ Palpitations (heart pounding)
___ Trouble Breathing at Night
___ Trouble Climbing Stairs
___ Ankle Swelling
___ Heaviness in chest

Gastrointestinal
___ Stomach/Abdominal pain
___ Indigestion/Heartburn
___ Ulcers
___ Difficulty swallowing
___ Vomiting
___ Changes in bowel habits
___ Hemorrhoids

Urinary
___ Pain with urination
___ Blood in urine
___ Frequent urination
___ Previous infections
___ Kidney Stones

Eyes
___ Glasses/Contacts
___ Eye pain
___ Excessive tearing
Date of last eye exam _____

Nose/Throat/Sinuses
___ Nosebleeds
___ Sore Throat
___ Hoarseness
___ Post Nasal Drip
___ Swelling

Joints & Back
___ Pain
___ Swelling
___ Stiffness
___ Deformity

Muscles
___ Pain
___ Weakness
___ Twitching
___ Cramps

Psychological
___ Nervousness
___ Depression
___ Unable to sleep
___ Nightmares

Ears
___ Loss of hearing
___ Ringing
___ Drainage
___ Hearing voices

Mouth
___ Dentures
___ Bleeding Gums
___ Toothache

Male
___ Hernia
___ Discharge from penis
___ Pain in testicles
___ Varicose
___ Erectile dysfunction

Female
___ Vaginal itching/burning
___ Vaginal discharge
___ Problem w/ menstruation
Last Period _____
Last Pap Smear_____
___ Method of contraception
___ Sexual difficulties
___ Pregnancy, #_____
___ Miscarriage/Abortions_____
___ Difficulty during pregnancy
___ Lumps in breast
___ Discharge from nipple(s)

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

MICHIGAN PREMIER INTERNISTS

Name:_____

DOB:__/__/____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
⑤	⑤	⑤	⑤

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Patient Financial Policy

Thank you for choosing our practice as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Co-pays

All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted. If you are unable to pay your copay AND past due balances, your appointment may need to be rescheduled.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the Insurance company that makes the final determination of your eligibility and benefits. If your insurance company does not pay for any of your services performed at our office, you may be responsible for the complete balance of the non-payable services. If we're out of network with your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. It is your responsibility to contact your insurance carrier.

Workers' Compensation and Automobile Accidents

You must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If your claim is litigated or you seek assistance from an attorney, your claims and all services will be treated as Patient Pay and you will be responsible for all charges.

Missed Appointments

We require 24-hour notice of appointment cancellation. Appointments missed and are not previously cancelled may be charged a fee of $25.00 for your missed appointment.

Returned-Checks

The charge for a returned check is $25 payable by cash, money order, credit or debit card. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis, following any returned check.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. If payment is not made on this account or you have not called to make payment arrangements, the account will be sent to the collection agency, or attorney, and possibly discharged from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs, and we will not be able to continue your care until the balance is paid In full.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

I,_____ have read the above financial policy and understand my financial responsibility to my healthcare provider. This policy replaces any prior financial policy signed and will be strictly enforced.

Patient Signature Date

Witness Date

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

ACKNOWLEDGMENT OF RECEIPT OF

PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the **Michigan Healthcare Professionals, P.C.** Patient Notice of Privacy Practices effective September 23, 2013.

Date: _____ Patient Signature: _____

(or Guardian, if applicable)

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29877 Telegraph Rd. Ste. 200
Southfield, MI 48034

Medical Records Release/Consent Form

Patient Name:_____ Today's Date: _____

Date of Birth:_____

Doctor/Physician:_____

I am authorizing to have my medical records mailed to my home address, e-mailed or faxed to me. If I am not available, I give my consent for you to give my medical information, records and/or test results to:

Name_____

Phone Number_____

Relation to Patient_____

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Medical Appointment Cancellation/No Show Policy

When you schedule an appointment with Michigan Premier Internists, we set aside enough time to provide you with the best quality care in our office. If you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an urgent appointment.

Be advised that we do enforce a 10 minute time policy. If a patient is late to their appointment by 10 minutes or more we reserve the right to not see that patient when they arrive. This is due to the fact that we always want to make sure we are being timely to our scheduled patients. Please be courteous and give the office a heads up if you know you are running late.

PLEASE SEE OUR APPOINTMENT CANCELLATION/NO SHOW POLICY BELOW:

Effective January 1, 2023 any patient who fails to show or cancels an appointment and has not contacted our office with a 24 hour notice will be considered a NO SHOW and be charged a $50.00 fee.

The fee will be charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

As a courtesy, we always make reminder calls, and texts are sent to those patients who are linked to the Beaumont MyChart system. These efforts try to ensure that the patient does not forget their scheduled appointment. We recommend that all patients sign up for the Beaumont MyChart app in order to receive messages about your appointments.

We understand there may be times when an emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office 24 hours before your appointment. You may contact our office Monday - Friday from 8:45am until 4pm with the exception of our lunch hour from 12-1pm daily.

I have read and understand the Medical Appointment Concellation/NO SHOW Policy and agree to its terms.

Patient Signature_____

Print Name/Date of birth_____

Date_____

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Welcome Patients!

At Michigan Premier Internists, we want all of our patients to get the best care possible. We would like you to tell us about your racial/ethnic background and preferred language so that we can review the treatment that all patients receive, and make sure that everyone receives the highest quality care.

Please know that the submission of this information is **voluntary.**

Gender:

- ❑ Male
- ❑ Female
- ❑ Decline to answer

Race:

- ❑ Asian
- ❑ Native American / Alaska Native
- ❑ Black / African American
- ❑ Native Hawiian / Pacific Islander
- ❑ White
- ❑ Other
- ❑ Decline to Answer

Ethnicity:

- ❑ Hispanic
- ❑ Not Hispanic ❑ Decline to answer

Preferred Language: ❑ English ❑ Arabic ❑ American Sign Language
❑ Bengali ❑ Chinese ❑ Hindi ❑ Japanese ❑ Spanish ❑ Decline to answer
❑ Other_____

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