

Preferred Medical Group , PC

Members of Beaumont Medical Staff

1200 W 12 Mile Road, Madison Heights, MI 48071 Phone 248.543.0600 Fax 248.543.4720

PATIENT INFORMATION

REF BY: _____

FULL NAME: _____

DATE OF BIRTH: _____ SSN# _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME # _____

SEX: MALE () FEMALE ()

WORK # _____

MARITAL STATUS: _____

CELL # _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT NAME/NUMBER: _____

EMPLOYER: _____

SPOUSE: _____ SPOUSE'S WORK# _____

RESPONSIBLE PARTY: _____

NAME: _____ RELATION _____

ADDRESS: _____ CITY _____

PHONE: _____

*****INSURANCE INFORMATION**
CONTINUED ON BACK OF SHEET**

PRIMARY INSURANCE CO. NAME

SUBSCRIBER NAME: _____

SUBSCRIBER'S S.S. # _____

SUBSCRIBER'S D.O.B. _____

RELATION TO PATIENT: _____

SECONDARY INSURANCE CO. NAME (IF APPLICABLE)

SUBSCRIBER NAME: _____

SUBSCRIBER'S S.S.# _____

SUBSCRIBER'S D.O.B. _____

RELATION TO PATIENT: _____

1. I AUTHORIZE BILLING AND RELATED INFORMATION TO BE SENT TO MY INSURANCE COMPANY.
2. I UNDERSTAND THAT EVEN IF I HAVE INSURANCE, I MAY BE RESPONSIBLE FOR PAYMENT OF SERVICES.

PLEASE CHECK ONE:

I AM INTERESTED IN RECEIVING INFORMATION ON ADVANCED DIRECTIVE AND LIVING WILLS AT THIS TIME.

I AM NOT INTERESTED IN RECEIVING INFORMATION ON ADVANCED DIRECTIVE AND LIVING WILLS AT THIS TIME.

SIGNATURE: _____ **DATE:** _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Constitutional Symptoms					
Fever	Y	N	Headache	Y	N
Chills	Y	N	Other	_____	
Eyes					
Blurred Vision	Y	N	Double Vision	Y	N
Pain	Y	N	Other	_____	
Ear/Nose/Throat/Mouth					
Ear Infection	Y	N	Sinus problems	Y	N
Sore throat	Y	N	Other	_____	
Respiratory					
Wheezing	Y	N	Shortness of breath	Y	N
Frequent cough	Y	N	Other	_____	
Gastrointestinal					
Abdominal Pain	Y	N	Indigestion/Heartburn	Y	N
Nausea/Vomiting	Y	N	Other	_____	
Genitourinary					
Urine retention	Y	N	Urinary frequency	Y	N
Painful urination	Y	N	Other	_____	
Musculoskeletal					
Joint pain	Y	N	Back pain	Y	N
Neck pain	Y	N	Other	_____	
Integumentary					
Skin rash	Y	N	Bolls	Y	N
Persistent Itching	Y	N	Other	_____	
Neurological					
Tremors	Y	N	Numbness/tingling	Y	N
Dizzy spells	Y	N	Other	_____	
Endocrine					
Excessive thirst	Y	N	Tired/sluggish	Y	N
Too hot/cold	Y	N	Other	_____	
Cardiovascular					
Chest Pains	Y	N	Varicose veins	Y	N
High blood Pressure	Y	N	Other	_____	
Hematologic/Lymphatic					
Swollen glands	Y	N	Blood clotting problem	Y	N
Other	_____				
Allergic/Immunologic					
Hay Fever	Y	N	Drug allergies	Y	N
Other	_____				
Psychologic					
Are you generally satisfied with you life?	Y	N			
Do you feel severely depressed?	Y	N			
Have you considered suicide?	Y	N			
Other	_____				

Please explain any Yes answers here.

Physician use only: (Comments/Notes)

#Answer Service	Level of
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician: _____

Date: _____



PREFERRED MEDICAL GROUP, PC

HIPAA AUTHORIZATION FORM

Preamble:

Yes No May we share your Protected Health Information (PHI) with a family member or other? Names:

Yes No May we leave routine / ordinary messages on my **HOME** Voice Mail

PHONE# (____) _____

Yes No May we leave routine / ordinary messages on my **MOBILE** Voice Mail

PHONE # (____) _____

Please **DO NOT LEAVE ANY** messages on my Voice Mail

Patient Authorization for use and Disclosure of Protected Health Information

By signing, I authorize **PREFERRED MEDICAL GROUP, PC** to use and/or disclose certain protected health information (PHI) about me to any doctor or health care facility that we refer you to **with your consent and understanding OR to** _____.

This authorization permits **PREFERRED MEDICAL GROUP, PC** to use and/or disclose the following individually identifiable health information about me, including but not necessarily limited to: Your handwritten and/or dictated office notes, lab, diagnostic and/or radio logic tests, therapeutic data and referral documents from other Health Care Providers, OR.

The information will be used or disclosed for the following purpose: To assist other Health Care Providers/Entities in providing your health care OR.

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual."). Included in this section is any entity that you have authorized to receive your medical records. In such cases, ALL of your chart data will be provided unless the request explicitly requests only specific information

I HAVE ACCESS TO THE FULL NPP HIPAA RULES IN THE OFFICE LOBBY AND UNDERSTAND THAT I MAY VIEW THEM AT MY LEISURE.

The purpose(s) is/are provided to that I can make an informed decision whether to allow release of the information. This authorization will expire upon your written request to resend this authorization.

The practice ____ will ____ will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **PREFERRED MEDICAL GROUP, PC**. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

I HAVE BEEN OFFERED A COPY OF THIS NOTICE AT THE TIME OF THIS SIGNING



PREFERRED MEDICAL GROUP, PC

PATIENT CONSENT FORM

Use of this form is optional and not required under the HIPAA privacy rule.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **PREFERRED MEDICAL GROUP, PC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by **PREFERRED MEDICAL GROUP, PC** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing the consent. **PREFERRED MEDICAL GROUP, PC** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **PREFERRED MEDICAL GROUP, PC**. With this consent, **PREFERRED MEDICAL GROUP, PC** may call by home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **PREFERRED MEDICAL GROUP, PC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, **PREFERRED MEDICAL GROUP, PC** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **PREFERRED MEDICAL GROUP, PC** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **PREFERRED MEDICAL GROUP, PC** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that he practices has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **PREFERRED MEDICAL GROUP, PC** may decline to provide treatment to me.

I HAVE ACCESS TO THE FULL NPP HIPAA RULES IN THE OFFICE LOBBY AND UNDERSTAND THAT I MAY VIEW THEM AT MY LEISURE.

Print Patient's name _____

Signed by: _____ **Date:** _____
Signature of Patient or Legal Guardian

Print Name on Legal Guardian, if applicable _____

Relationship to patient: _____

--THIS PAGE IS OPTIONAL--



Preferred Medical Group, P.C.

Board Certified Family Medicine / Geriatric Medicine / General Surgery / Physical Medicine / Cardiology

Members Beaumont Medical Staff

1200 WEST TWELVE MILE ROAD MADISON HEIGHTS MI 48071 248.543.0600 248.543.4720 (fx)

To our patients:

As you know if you ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount you share. At this time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This is no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of visit, of course, still are due at the time of service. If you have any questions about this method, do not hesitate to ask.

Sincerely,
Preferred Medical Group, P.C.

--THIS PAGE IS OPTIONAL--

I authorize Preferred Medical Group, P.C. to charge outstanding balances on my account to the following credit card:

VISA MASTERCARD AMERICAN EXPRESS OTHER: _____

Account number _____ Expiration Date: _____

Name on card (please print) _____

Signature _____ Date _____

Marc Weisman, DO, FAAFP / Jason Talbert, MD / Alan Carbajo, MD / Tara Caudill-Deaton, MD
Michelle Petropoulos, PA-C / Heidie Vasko, PA-C / Dwijen Misra, MD
Jim M. Newman, MD/ Hilary Rosenthal, DPM