Main Street Physicians PC
INTERNAL MEDICINE

# WELCOME

Welcome to Main Street Physicians P.C. We look forward to becoming your partners in health and meeting your healthcare needs through quality, comprehensive, patient-centered care.

## SCHEDULING APPOINTMENTS

Please call during normal business hours to schedule an appointment. Appointments for PHYSICAL EXAMS and ROUTINE VISITS are available upon request. We offer SAME-DAY appointments for sudden, unexpected concerns. Please note that same-day appointments are limited to acute problems, only, and do not take the place of a regular, comprehensive visit.

## REGULAR OFFICE HOURS

| | |
|---|---|
| Monday | 10:00am-6:00pm |
| Tuesday | 8:00am- 4:30pm |
| Wednesday | 9:00am- 3:00pm |
| Thursday | 8:00am- 4:30pm |
| Friday | 8:00am- 3:00pm |

***PHONES ARE OFF DURING LUNCH HOURS, 12-1***

### BEAUMONT URGENT CARE
18930 West Road, Woodhaven

### BEAUMONT-TRENTON EMERGENCY ROOM
5450 Fort Street, Trenton

### HENRY FORD HEALTH CENTER- BROWNSTOWN
23050 West Road, Brownstown

## AFTER-HOURS EMERGENCIES

If you have a life-threatening emergency, please call 911 or proceed to the nearest emergency room. It is your responsibility to inform the practice regarding care received elsewhere. If you have an urgent medical problem and the office is closed, your provider may be reached by dialing 734-676-3373 and choosing OPTION 5 to leave a message. Please note, this is not for medication refills or referral requests. All non-medical issues will be addressed during normal business hours.

## REFERRALS

It is your responsibility to know your insurance requirements. If your insurance requires a referral to see another provider or have a test, please schedule an appointment with our office to discuss with your provider. We require 5 business days to process your referral.

Please note, referrals are granted at the discretion of your provider. Day-of-service requests are not granted. Post-dated referrals for costs incurred seeking or receiving care without a proper referral will not be granted.

## FIRST VISIT AND FOLLOW-UP VISITS

Please arrive at least 30 minutes prior to your initial visit and check in at the reception desk. Please notify the receptionist each visit of any changes in name, contact information, or insurance coverage. Verifying this information at each visit will help ensure the services you receive are covered by your insurance company. Prior to your first or following visits, it is your responsibility to verify with your insurance company that our providers are "in-network."

We don't like to make you wait and make every effort to keep our scheduled appointments on time. However, unavoidable circumstances or emergencies may result in a delay in seeing the provider. We appreciate your patience and understanding in such circumstances.

If you need to cancel or reschedule an appointment, please notify our office within 24 hours. Not showing up for a scheduled appointment may result in a cancellation fee (please see our missed appointment policy).

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# WELCOME

## PRESCRIPTIONS AND REFILLS

We electronically prescribe ALL prescriptions. It's the law. Prescription refills are issued during normal business hours. If you require a refill, please call or message us with your request. Please note, pharmacies do not request refills, you do. Also, please check with your insurance provider regarding pharmacy benefits, medication formulary, and preferred pharmacy.

While medication coverage is often difficult to predict, we make every effort to prescribe medications that are both effective and affordable. If your medication is not covered, please discuss with your pharmacist, then contact our office to request "the next step" towards coverage or finding an alternative. We are here to help, but it's not always an easy or straightforward process! We kindly ask for your patience.

Medication refills require regular follow-up appointments, as established by your provider. Quantities may be tapered, limited, or denied without proper follow-up.

## FMLA/DISABILITY PAPERWORK

Requests for FMLA/disability paperwork require a scheduled appointment to discuss. Your practitioner reserves the right to grant, deny, or modify FMLA based on his or her assessment of your conditions/circumstances. The fee for FMLA paperwork is $30 due, in full, prior to completion. Paperwork will be completed within five business days.

## LAB WORK

Beaumont Laboratory operates a blood draw station in our building that is independent from our practice. This is a wonderful convenience for our patients and practitioners. Requisitions for lab work must be obtained from your provider DURING an office visit and PRIOR to having lab work drawn. Same day requests will not be granted. All laboratory billing is through Beaumont Laboratory and has no association with Main Street Physicians P.C.

## CODE OF CONDUCT

Main Street Physicians is committed to providing high-quality health care designed to help those we serve. Our patients, visitors and staff are entitled to a safe, caring and inclusive environment. Words or actions that are disrespectful, discriminatory, hostile or harassing are not welcome. Examples of these include:

- Physical abuse, assault or battery
- Aggressive behavior such as physical or verbal threats
- Discriminatory behavior regarding others' race, ethnicity, accent, religion, gender, sexual orientation or other personal traits
- Sexual or vulgar words or actions
- Disrupting another patient's care or experience
- Recording patients, visitors or staff without their consent

Our office is a healing environment, and these behaviors will not be tolerated. Though we expect such incidents to be rare, violators of this Code of Conduct may be asked to make other plans for their care.

If you witness or are the target of any of these behaviors, please report it to a member of our staff.

*"Be kind and compassionate to one another." - Ephesians 4:32 NIV*

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# YOUR PATIENT CENTERED HOME

We continuously strive for better ways to serve your healthcare needs. That's why Main Street Physicians P.C. has implemented the Patient Centered Medical Home (P.C.M.H.) model.

As a P.C.M.H., Main Street Physicians P.C. will work towards new and better ways to coordinate your care. This comprehensive, proactive approach is meant to improve the quality of your care and, hopefully, your overall health.

The details of P.C.M.H. may be discussed further during your appointment. Your physician will lead the team, with the goal of improving your healthcare experience through a stronger patient-provider relationship.

## PROVIDER RESPONSIBILITIES:

- A physician-directed healthcare team.
- Goal setting and care plan developed with you, your family, and your healthcare team.
- Increased appointment availability, extended office hours and/or access to urgent care services, and same-day appointments.
- Referrals and coordination of care with trusted specialists and community resources.
- Sharing health information with care partners to improve quality and promote comprehensive care.
- Set communication expectations regarding test results and other medical services.

## PATIENT RESPONSIBILITIES:

- Ask questions, share your feelings, and be an active participant in your healthcare plan.
- Be open when asked about your health history, symptoms, and other important information about your health.
- Call your primary care physician (P.C.P.) team first with any medical problems, unless it is a medical emergency.
- Bring any test results done by other physicians back to your P.C.P.'s office.
- Follow your treatment plan, including filling and taking medications as directed.
- Keep all scheduled appointments.

telephone (734)676-3373 fax (734)676-2014 – 25000 Hall Road, Suite One, Woodhaven, MI 48183

Main Street Physicians PC
INTERNAL MEDICINE

# FINANCIAL POLICY

Main Street Physicians P.C. (the "Practice") intends to foster an open and respectful relationship between our patients, physicians, and other health care practitioners. Our goal is to provide the best possible care and treatment for our patients. Part of providing the best possible care and treatment is communicating our payment and financial policy to you so that you understand what is expected. Although we are healthcare providers first and foremost, the Practice is also a business with employees, payroll, overhead and other expenses. Accordingly, the following provisions reflect our policy with respect to your financial obligations to the Practice:

1. **PAYMENT:** Payment is due before services are rendered. The Practice accepts cash, check, or debit and/or credit card payment. You are responsible for any unmet deductible, co-payment and/or co-insurance amounts, as well as any charges for items and services rendered which are not covered by your health insurance policy. If you do not have health insurance, payment in full for the items and services rendered is due at the time of service.
2. **DOCUMENTATION:** The Practice requires and requests that you provide a driver's license or state identification card, social security number as well as your health insurance card or other proof of insurance. Proper identification is necessary to guard against identity theft and other fraud, while maintenance of current insurance information promotes proper and timely payment. The Practice will maintain such information in strict confidence and will only provide access to such information to employees with a need to know. Otherwise, such information shall be safeguarded in accordance with applicable laws and regulations.
3. **INSURANCE:** You are responsible for knowing the nature and scope of your health insurance coverage. Please contact your health insurance provider if you have any questions about coverage and benefits. The Practice and its health care practitioners participate with many insurance companies and/or plans. It is possible that our practitioners are not participating providers with your company and/or plan. Further, it is also possible that some or all the services the Practice provides at a given time may not be covered by your insurance company and/or plan. You will nevertheless be responsible for the payment of such items and services.
4. **ASSIGNMENT:** By your acknowledgment and execution of this Payment Policy, you agree to assign, transfer, and set over to the Practice the applicable benefits of insurance to which you are or may be entitled in order to pay for the care and treatment provided to you (or your dependent beneficiary).
5. **DELINQUENT ACCOUNT/NONPAYMENT:** In the event that payment is not made in accordance with this policy, and your account becomes past due by ninety (90) days, the Practice may engage a collection agency to pursue payment, among other remedies available to the Practice under the law. Additional reasonable fees incurred attendant with collection will be added to the outstanding balance and you agree to pay such additional fees.
6. **CONTACT US:** In the event that you have any questions about this policy and/or about any fees, charges and payment, you may contact Physicians Revenue Group at (734) 373-1173.

I have read this Payment Policy and I understand and agree to be bound by the provisions set forth above, as the same may be amended and communicated to me from time to time.

_____ _____

Signature of Patient (or Guarantor) Date

_____

Print Name

telephone (734)676-3373 fax (734)676-2014 – 25000 Hall Road, Suite One, Woodhaven, MI 48183

Main Street Physicians PC
INTERNAL MEDICINE

# MISSED APPOINTMENT POLICY

Our goal is to provide quality, individualized medical care in a timely manner. NO-SHOWS, LATE-SHOWS and LATE CANCELLATIONS inconvenience others who may need access to medical care. We would like to remind you of our policy regarding missed appointments.

## CANCELLATIONS

We kindly ask that you be respectful of the needs of others. Please call our office promptly if you are unable to show up for a scheduled appointment. This time may be reallocated to someone else in need of treatment.

If you need to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand and your early cancellation will allow others timely access to medical care.

To cancel your appointment please call 734-676-3373. If you do not reach the receptionist, you may leave a detailed message on our voice mail. If you would like to reschedule your appointment, please leave your name and phone number. You may also request to cancel through your MyChart patient portal.

## LATE CANCELLATIONS

A cancellation is late when the appointment is cancelled without 24-hour advance notice.

## NO SHOW POLICY

A NO-SHOW is an appointment that is missed without properly cancelling. These missed appointments are recorded in your chart.

A 1st time NO-SHOW, LATE CANCELLATION will incur no charge.

A 2nd occurrence will result in a charge for the missed visit.

A 3rd occurrence may subject you to no further future appointments and potential discharge from the practice.

_____ _____

Signature of Patient (or Guarantor) Date

_____

Print Name

telephone (734)676-3373 fax (734)676-2014 – 25000 Hall Road, Suite One, Woodhaven, MI 48183

# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | Date of Birth: / / |
|---|---|---|---|
| Street address: | | | Home phone no.: |
| Address second line: | City: | State: | ZIP Code: |

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:*

## DISCLOSURE CONTACT INFORMATION

| Name: | | | |
|---|---|---|---|
| Street address: | | | |
| Address second line: | City: | State: | ZIP Code: |

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).
   - _____ Complete health records
   - _____ Lab results/X-ray reports
   - _____ Physical exam
   - _____ Consultation reports
   - _____ Immunization record
   - _____ Other (please specify: _____)
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. *This information may be disclosed to and used by the following individual or organization.*
   **Main Street Physicians , P.C.**
   25000 Hall Road, Suite One
   Woodhaven, MI 48183
   Fax (734) 676-2014

*For the purpose of*: Continuing care

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____

*Signature of patient or legal representative* *Date*

_____ _____

*Signature of witness* *Date*

***PLEASE NOTE:*** *This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.*

# RECEIPT OF NOTICE OF PRIVACY PRACTICES

Main Street Physicians PC
INTERNAL MEDICINE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January, 1 2019 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Prior to making any significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations in accordance with applicable law in the following ways:

**Treatment:** We may use and disclose your health information to a physician, physician's assistant, or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. This may include certain activities that your health insurance plan may undertake before or after it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a stay at one of our treatment centers may require that your relevant protected health information be disclosed to the health plan to obtain approval for admission to the center.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include appointment scheduling, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, and conducting training programs, accreditation, certification, licensing or credentialing activities.

We will share your protected health information with third party "business associates" that perform various activities (e.g., legal or accounting services) for the practice. Whenever an arrangement between our facilities and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you provide us with an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so, except as otherwise described in this Notice. Accompaniment implies your consent.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare.

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, our physician or physician's assistant shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If our physician or another physician or physician's assistant is required by law to treat you and the physician or physician's assistant has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

**Communication Barriers:** We may use and disclose your protected health information if our physician or another physician or physician's assistant attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician or physician's assistant determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security and Correctional Facilities:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose protected health information to correctional institution or law enforcement officials having lawful custody of an inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

# RECEIPT OF NOTICE OF PRIVACY PRACTICES

Main Street Physicians PC
INTERNAL MEDICINE

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies, government benefit programs, other government regulatory programs and civil rights agencies.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products, to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may also disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his or her duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Workers' Compensation:** Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Required Uses and Disclosures:** Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR Section 164.500 et. seq.

## YOUR RIGHTS

**Access:** You have the right to look at or receive copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page and $15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to yourself. If you request an alternative format or films or videotapes, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

**Electronic Access:** You have the right to access protected health information in an electronic format if we maintain protected health information in such format, subject to a reasonable cost-based fee.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests. For electronic health records, the list of disclosures is limited to the last 3 years but applies to all disclosures made by us regardless of purpose.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but, if we do agree, we will abide by our written agreement signed by you and us (except in an emergency). We are required to agree to a request for restriction if it relates to a disclosure to a health plan for purposes of carrying out payment or health care operations and the PHI pertains solely to a health care item or service for which we have been paid by you **out-of-pocket in full**.

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may submit a complaint to us

# RECEIPT OF NOTICE OF PRIVACY PRACTICES

Main Street Physicians PC
INTERNAL MEDICINE

using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

| | | | |
|---|---|---|---|
| Contact Officer: | Office Manager, Main Street Physicians P.C. | Fax: | 734-676-2014 |
| Telephone: | 734-676-3373 | E-mail: | officemgr@mainstreet-physicians.com |

_____ _____

Patient Name Date

By signing below, I acknowledge that I have received a copy of Main Street Physicians PC Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by MainStreet Internal Medicine and of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

_____ _____

Patient Signature Date

_____ _____

Witness Date

# REGISTRATION FORM

Main Street Physicians PC
INTERNAL MEDICINE

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Patient's last name: | First: | | | Middle: | |
| Today's Date: / / | ☐ Mr ☐ Mrs ☐ Miss ☐ Ms | | Marital status (circle one) Single / Mar / Div / Sep / Wid | | |
| Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ☐ M ☐ F |
| Email: | | Home phone: | | Cell phone: | |
| Street address: | | Work phone: | | Social Security no.: | |
| Address second line: | City: | | State: | ZIP Code: | |
| Occupation: | Employer: | | | Employer phone no.: | |

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. _____

☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

## INSURANCE INFORMATION *(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)*

| | | | | | |
|---|---|---|---|---|---|
| Person responsible for bill: | Address (if different): | | | Home phone no.: | |
| Is this person a patient here? ☐ Yes ☐ No | Birth Date: / / | | | | |
| Occupation: | Employer: | Employer address: | | | |
| Is this patient covered by insurance? ☐ Yes ☐ No | Employer phone no.: | | | | |

Please indicate primary insurance ☐ Medicare ☐ BCBCM ☐ BCN ☐ HAP ☐ United ☐ Aetna ☐ Priority ☐ Cofinity

☐ Other: _____

| | | | | | |
|---|---|---|---|---|---|
| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $ |
| Patient's relationship to subscriber: | ☐ Self ☐ Spouse ☐ Child ☐ Other | | | | |
| Name of secondary insurance (if applicable): | Subscriber's name: | | Group no.: | Policy no.: | |
| Patient's relationship to subscriber: | ☐ Self ☐ Spouse ☐ Child ☐ Other _____ | | | | |

## IN CASE OF EMERGENCY

| | | | |
|---|---|---|---|
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MainStreet Internal Medicine or insurance company to release any information required to process my claims.

_____ _____

*Patient/Guardian signature* *Date*

telephone (734)676-3373 fax (734)676-2014 – 25000 Hall Road, Suite One, Woodhaven, MI 48183

Main Street Physicians PC
INTERNAL MEDICINE

# HEALTH HISTORY (CONFIDENTIAL)

Name: _____ Today's Date: _____

Age: _____ What is your reason for the visit? _____

| CURRENT MEDICAL CONDITIONS *(HIGH BLOOD PRESSURE, DIABETES, HIGH CHOLESTEROL, ETC.)* | PAST SURGERIES & HOSPITILIZATIONS *(INCLUDE DATES)* |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**FAMILY HISTORY**

| Relation | Age | State of Health | Age at Death | Health Problems |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| | | | | |
| | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**PERSONAL INFORMATION**

Occupation? _____

☐ Single ☐ Married

☐ Smoker ☐ Non-Smoker ☐ Ex-Smoker

How much per day? _____

Year quit _____

Do you drink alcohol? ☐ Yes ☐ No

Type? _____

How many drinks per day? _____

How much coffee/pop (caffeinated) do you drink daily? _____

Exercise? _____

Do you use any illegal drugs? ☐ Yes ☐ No

Type? _____

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Main Street Physicians PC
INTERNAL MEDICINE

# HEALTH HISTORY (CONFIDENTIAL)

| HEALTH PREVENTION & SCREENING HISTORY *(TELL US WHAT'S BEEN DONE IN THE PAST TO MONITOR YOUR HEALTH)* | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **GENERAL TESTING** | | | **FOR MEN ONLY** | | | **FOR WOMEN ONLY** | | |
| **Test** | **Year** | **Result** | **Test** | **Year** | **Result** | **Test** | **Year** | **Result** |
| Colonoscopy | | | Prostate Exam | | | Pap Smear | | |
| Sigmoidoscopy | | | PSA | | | Breast Exam | | |
| Diabetes check | | | Prostate Biopsy | | | Mammogram | | |
| Cholesterol check | | | | | | Last period | | |
| Bone Density | | | | | | Gynecologist | | |
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| CURRENT MEDICATIONS | | DRUG ALLERGIES |
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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

telephone (734)676-3373 fax (734)676-2014 – 25000 Hall Road, Suite One, Woodhaven, MI 48183