Patient's Name _____

(Please Print)

YOUR APPOINTMENT
DATE
TIME
LOCATION

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 Spectrum Health.

Appointment information:

- **Bring photo ID & insurance card**
- **We will be collecting any co-pay, co-insurance, or deductible.**
- **Bring in your medications in their original containers.**

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.

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

Sincerely,
Michigan Primary Care Partners Staff

DIRECTIONS TO OUR LOCATIONS

Michigan Primary Care Partners – Big Rapids

20095 Gilbert Road, Suite B, Big Rapids, MI 49307

Now partnered with West MI Pharmacy in the Big Rapids Location

US-131 exit 139 – Perry Street. Turn East onto Perry St and continue past Wal-Mart to State Street (2 Miles). Turn South on State Street, drive 1 mile and turn right (West) onto Gilbert Road. The office is on the left-hand side.

Michigan Primary Care Partners – Reed City

22018 Professional Drive, Reed City, MI 49677

US-131 exit 153 – US-10. Head East on US-10 and take first right onto 220th Ave. Continue for .6 miles. The office is on the right, across from Reed City Hospital.

Michigan Primary Care Partners – Grand Rapids

4024 Park East Court SE, Suite C, Grand Rapids, MI 49546

I-96 exit 40 – Cascade Road West. Drive for .5 miles. Turn South onto East Paris. Drive 1.5 miles on East Paris. Turn left onto Park East Court. Our office is located in the same building as Chemical Bank.

Michigan Primary Care Partners-Canadian Lakes

8540 105th Avenue, Stanwood, MI 49346

US-131 exit 131- Turn East onto 8 mile road, continue straight until you reached the end of 8 mile road. Take a left onto 155th ave. Then a quick right onto Buchannan Rd. Continue for approx. 3.5 miles. Turn left onto 105th ave. Our office is located behind the Canadian Lakes Area Real Estate Information Center.

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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	Relationship to Patient	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

Michigan Primary Care Partners 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**

_____

Date

_____

Patient Name (Printed)

_____

Patient Signature

_____

Patient Representative Name (Printed)
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

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
(Required if the patient is a minor or an adult who is unable to sign this form)

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PERMISSION TO ACCESS DATA FROM SPECTRUM HEALTH'S INFORMATION SYSTEM

I hereby authorize **Michigan Primary Care Partners, PC** (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 Spectrum Health. 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.

_____ _____

Patient's Signature (parent/guardian) **Date**

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

Date of Birth _____/_____/_____ **Social Security #** _____ **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 (print name) _____ Signature: _____

Parent / Guardian: _____ 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

PATIENT FINANCIAL POLICY

As a courtesy to our patients, we bill their insurance carrier(s) for all appropriate medical fees. **However, we require that our patients pay any portion not covered by their insurance, due to deductibles and co-pays, on the day of service.** Health insurance is a contract between the patient and their insurer. Although we file insurance claims as a courtesy to our patients, it is important to remember that the person receiving the services*, the patient*, is ultimately responsible for ensuring that full payment of services is made, regardless of the amount their insurance carrier covers. Failure to provide accurate billing information at the time of service will result in all fees becoming the responsibility of the patient (or legal guardian representing the patient). It is the patient's responsibility to provide their insurance carrier with any requested information needed to process their claim in a timely manner. Failure to provide requested information to a patient's insurance carrier within thirty (30) days of such request will result in all fees becoming the responsibility of the patient (or legal guardian representing the patient).

Balances Due After Insurance Pays: If an account balance remains after your insurance carrier pays, you have 30 calendar days to make a payment on the invoice. Payments not made within 30 days are considered Past Due. Payments not made within 120 days are considered Delinquent.

Collections: Patients who have not attempted to pay their copay, deductible or other (non-insurance covered) amounts totaling $100 or more for a period of greater than 120 days will have billing account information forwarded to an attorney and/or third party collections agency.

Delinquent Accounts and Waiver of Confidentiality: You understand that if your billing account information is submitted to an attorney and/or third party collection agency, if we are required to litigate in court, or if your past-due status is reported to an agency, the fact that you received treatment at our facility may become a matter of public record. In the event of a delinquent account you agree to pay all collection agency fees. You also agree to pay all court fees, the maximum amount of interest allowed by law, and any attorney fees incurred due to your delinquency.

Notice of "Non-Covered" Services: Please review your healthcare policy very carefully prior to receiving services. Once services are rendered, you remain entirely financially responsible for any services performed at this facility that are considered *non-covered* by your insurance carrier.

ASC Deposit Required: If you are utilizing our facility to undergo an ambulatory surgery center (ASC) procedure, we will verify your insurance benefits and obtain appropriate authorizations from your insurance carrier in advance of your scheduled procedure date. Once your insurance carrier determines your deductible, co-payment and/or co-insurance amounts due for your planned surgical procedure, we will collect the full amount of *your* expected financial liability from you, **prior to your planned procedure**. Failure to pay this amount upon arrival to the facility will result in your removal from the schedule on that day.

If You Have:

-Regular Medicare without a Secondary Insurance: Payment of your 20% co-pay is due at the time of your visit.

-Regular Medicare with a Secondary Insurance or Medigap: No payment is due at the time of your visit.

-A Worker's Compensation Claim: Call your carrier ahead of time to verify the accident date, claim number, primary care physician, employer information, and referral procedures. If we have verified the claim with your carrier then no payment is necessary at the time of your visit. If we are not able to verify your claim then payment in full will be required at the time of your visit. If your claim is denied you will be responsible for payment in full.

-A Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require written verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow

–A Personal Injury (continued): us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of your bill remains your responsibility. We cannot bill your attorney for charges incurred during your personal injury case. You also realize that we have a lien on any personal injury settlement pursuant to N.C.G.S. 44-49, et seq and you authorize your attorney or liability carrier to pay those lien amounts to us out of any settlement proceeds without further authorization from you.

-Out of Network / Non-Participating Insurance: If we are not in network with your insurance carrier, we will bill your carrier as a courtesy to you. If the balance is not received within sixty (60) days, the balance becomes your responsibility. Please be aware that you may incur more out-of-pocket expenses for receiving medical care out-of-network. You, the

patient, will have to contact your insurance company to determine why payment has not been paid. It is your responsibility to check with your insurance carrier for benefit coverage.

-Self-Pay: We require that patients with self-pay balances to pay their account balances to zero ($0) prior to future appointments being made.

Referrals: If your insurance carrier has designated a primary care physician (PCP), you are most likely to have prior authorization from your PCP prior to your visit. If this authorization is not provided at the time of your appointment, you will be required to reschedule.

Maximum Account Balance: If your account balance exceeds $500 (includes copay, deductible or other non-insurance covered amounts) we will not provide additional services until your account balance falls below the $500 balance limit.

Insurance Forms; Medical Records; and Disability Forms: We charge an administrative fee for completing insurance forms, medical records requests; and for completing disability verification forms. Please be aware that these services may require up to 7 to 10 business days to complete.

Transferring Records: You will need to submit a written request and pay a reasonable administrative fee if you wish to have a copy of your medical records for yourself or sent to businesses other that healthcare organizations. Medical records requested and sent to other healthcare organizations will be made available free of charge.

Returned Check Fee: In the event that we receive a returned check, due to insufficient funds, a $35 fee will be charged to your account and additional services will not be provided until your account is paid in full.

Acceptable forms of Payment: For your convenience, we accept cash, check, MasterCard and Visa. We also offer *CareCredit* ™ financing, which is a low-cost financing alternative for medical care. Our billing representatives would be happy to explain these services to you.

I state that I have read and fully understand the MPCP/WMP Patient Financial Policy and agree to abide by the terms specified above.

_____	_____	_____
Patient or Legal Guardian 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 Legal Guardian Signature	Relationship to Patient	Date

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24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Michigan Primary Care Partners Physicians reserve the right to charge a fee of $35.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed directly to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in discharge from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients and all locations.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

Sincerely,

The physicians and staff of Michigan Primary Care Partners

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

MEDICAL HISTORY

Name_____ **Date of Birth** _____/_____/_____

Is there another physician's office you would like us to contact to obtain your records? Yes _____ No _____

If **yes** please fill out the Medical Records Release on page next page of the new patient packet.

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**
□ **Bronchitis**	□ **Bowel irregularity**	□ **Depression**	□ **Allergy/Hay fever**
□ **Asthma**	□ **Sexual/menstrual dysfunction**	□ **Nervousness**	□ **Incontinence**

COMMENTS/OTHER

Allergies/Reactions

Allergies	Reaction	Allergies	Reaction
Example: Iodine	Hives	Example: Shellfish	Swelling of face and throat

Medications – ALL (Prescriptions, Over the Counter, Herbal)

Name	Strength	Directions
Example: Lasix	40 mg	1 tablet daily – Once Daily

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Medical Records
20095 Gilbert Road
Big Rapids, MI 49307
231.592.1360 (ph)
231.592.1361 (fax)

AUTHORIZATION FOR RELEASE OF INFORMATION MEDICAL/BILLING

Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Release Information From:

- ☐ MPCP/WMP-20095 Gilbert Road, Big Rapids, MI 49307
- ☐ WMP- 4024 Park East Court, SE Grand Rapids, MI 49564
- ☐ WMSC- 20095 Gilbert Road, Big Rapids MI 49307
- ☐ OTHER: _____

_____
(name, address, phone/fax)

Release Information To:

- ☐ MPCP/WMP-20095 Gilbert Road, Big Rapids, MI 49307
- ☐ WMP- 4024 Park East Court, SE Grand Rapids, MI 49564
- ☐ WMSC- 20095 Gilbert Road, Big Rapids MI 49307
- ☐ OTHER: _____

_____
(name, address, phone/fax)

This release is subject to such limitations as indicated below:

- ☐ Complete medical record
- ☐ Operative/Procedure notes
- ☐ Physician Notes, H&P, Discharge Summary
- ☐ Detailed billing information
- ☐ Radiology/Laboratory Reports
- ☐ Consultations
- ☐ Medication/Vaccination Records
- ☐ Other_____

Dates of Treatments From: _____/_____/_____ To: _____/_____/_____

I understand that I have the right to revoke this consent at any time unless information has already been released in reliance upon my previous consent. Submitted a written notice of revocation to the releasing party may revoke my consent. I understand this authorization is only valid for the date of signature and prior; no future dates or records will be released. I also understand that there may be fees associated with this request, based in limits set by Michigan State Law.

I hereby release_____, its employees, staff and agents from any liability which may arise as a consequences of the disclosure of the information set forth above relating to my medical/billing records.

Signature: _____ Date: _____
Parents or Guardian

Witness: _____ Date: _____

Any subsequent disclosure of medical/billing information by the recipients is prohibited without the express written consent/authorization from the above-name patient/guardian.

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FAMILY HISTORY

	Father	Mother	Brother(s)	Sister(s)	Son(s)	Daughter(s)
Is Deceased?	☐	☐	☐	☐	☐	☐
Cause						
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer Kind:	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
How Many?						

Women's Health

Appointment Type	Date
Last Pap Smear: **Where:**	
Last Mammogram: **Where:**	

Hospitalization or Surgery

Reason	Date

Lifestyle

Smoke: Yes_____ No_____ Packs daily _____ How Long? _____ Interested in Quitting? _____

Coffee: Cups Daily _____ Pop _____ Other Caffeine _____

Alcohol: Yes_____ No_____ Amount per Week _____

Diet: Salt Intake _____ Fat Intake _____

Sleep: □ Difficulty falling asleep □ Continuity disturbances □ Snoring □ Daytime drowsiness
□ Early morning awakening

Exercise: Yes_____ No _____ How Many Times per Week? _____

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

To: MICHIGAN PRIMARY CARE PARTNERS, PC D/B/A MEDICAL SPECIALISTS

_____ _____ _____/_____/_____

Patient Last name **Patient First name** **Date**

_____

Patient Signature

_____ _____

Patient Representative Signature **Patient Representative Relationship**

Persons/organizations to whom your personal health information/PHI may be disclosed:

_____

_____

By initialing in the TWO boxes below you the patient/guardian are agreeing and/or understanding the preset answers to be correct.

Information to be disclosed or used: **ALL** ☐ Please initial box

OR

OTHER: _____

example: diagnostic testing/labs

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.

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Dear Valued Patient,

We are honored that you have chosen us as your healthcare provider. Today we have exciting news regarding your health management!

As we continue in our efforts to provide our patients with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware of, but also involved in the management and improvement of your health.

We are proud to inform you that our practice now offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The "Patient Portal" enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely *via* the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the Portal to view their personal and private documents.

The Patient Portal makes it **Easy** for you to:

- **Ask your doctor, nurse, or a staff member a question**
- **Request prescription refills***
- **Request NON-URGENT appointments and view upcoming appointments**
- **Receive appointment reminders**
- **Verify and / or update current medication list**
- **View your personal health record**
- **Examine your current and past billing statements**
- **Receive our monthly e-newsletter**

This can all be done from the comfort and convenience of your home!
Begin today and take an active role in managing your healthcare!

To get signed up today, please fill out the following information and hand to the receptionist when checking in. They will then provide you with a username, password, and website info.

Patient Name: _____ D.O.B. _____

Email Address _____

Visit us online a

****Medication refills will be addressed within 1-4 business days.**