WELCOME TO THE PRACTICE!

Thank you for choosing Novi Internal Medicine & Pediatrics as your Family’s Physicians.

We pride ourselves on providing thoughtful medical care for your whole family.

AS YOUR PHYSICIANS WE WILL BE RESPONSIBLE FOR PROVIDING YOU WITH THE FOLLOWING SERVICES:

• Communication of lab results and other testing in a timely manner
• Recommending & providing Immunizations to prevent diseases
• Inpatient (hospital) services at Royal Oak Beaumont Hospital & Providence Park Novi
• Providing you with educational resources that help you manage your chronic diseases & promote good health
• Work together with other members of your medical team to share in decisions about your care
• Save space during our day to accommodate sick visits
• Have Saturday appointments available for patients that cannot be seen during the week
• Participate in PATIENT CENTERED MEDICAL HOME to help you accomplish your personal health care goals
• Have a physician on call & available by phone 24/7 for emergencies

AS A PATIENT OF OUR PRACTICE:

• We recommend you are seen once a year for an ANNUAL PHYSICAL, and adhere to a follow up schedule provided by your physician depending on your personal medical history
• Please provide our name to all specialists or other physicians to allow us to obtain your records and participate in all aspects of your care
• Carry a card with you at all times with a list of medications and your physician’s name
• Please allow up a 5 day lead time for referrals and 3 days for refills
• Attempt to see the same physician for routine health maintenance visits
• Understand that quality medical care requires face to face time and to this end:
  o We cannot routinely provide narcotics by phone
  o We cannot routinely provide antibiotics over the phone
  o Understand that most medical issues are best addressed in an office visit rather than by phone

We hope to partner with you to achieve your best health. Please let your provider know if you have any questions about this information.

DRS. EINHORN, GOLDEN, LEFF & ROSENBERG
**History of the Present Illness**

What is the reason for your visit today?:

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________

Are you having any problems with pain?:  □ No  □ Yes  If yes, describe:

_________________________________________________________________________________________________________

**Past Medical History**

Please list current and past medical problems that you have been treated for:

<table>
<thead>
<tr>
<th>Illness or Medical Problem</th>
<th>Physician Who Treated You</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Alcoholism</td>
<td></td>
</tr>
<tr>
<td>☐ Allergy or Asthma</td>
<td></td>
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<tr>
<td>☐ Arthritis</td>
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<tr>
<td>☐ Bleeding Disorder</td>
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<td>☐ Cancer</td>
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<td>☐ Diabetes</td>
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<td>☐ Glaucoma</td>
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<td>☐ Heart Trouble</td>
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<td>☐ High Blood Pressure</td>
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<td>☐ High Cholesterol</td>
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<tr>
<td>☐ HIV or AIDS</td>
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<tr>
<td>☐ Kidney Stones</td>
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<tr>
<td>☐ Obesity</td>
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<tr>
<td>☐ Reaction to Anesthetic</td>
<td></td>
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<tr>
<td>☐ Seizures</td>
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<tr>
<td>☐ Stroke</td>
<td></td>
</tr>
<tr>
<td>☐ Thyroid Disorders</td>
<td></td>
</tr>
</tbody>
</table>

**Past Surgical History**

Please list your previous surgeries, and the year that you had the surgery done in.

<table>
<thead>
<tr>
<th>Surgery (Any reaction to Anesthetic □ No □ Yes)</th>
<th>Hospital</th>
<th>Year</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**Current Medications**

Please list all medications you are now taking, including those you buy without a doctor’s prescription (such as aspirin, cold tablets, nutritional supplements, and/or herbal medicines).

<table>
<thead>
<tr>
<th>Name</th>
<th>Strength</th>
<th>Frequency</th>
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<tbody>
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</tbody>
</table>
### Allergies and Sensitivities
List any allergies to medications or foods that you may have and indicate how each affects you.

<table>
<thead>
<tr>
<th>Allergic To</th>
<th>Reaction</th>
<th>Allergic To</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

### Immunizations

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Tetanus Booster</td>
<td></td>
<td>Recommended every 10 years</td>
</tr>
<tr>
<td>Last Influenza (flu vaccine)</td>
<td></td>
<td>Recommended for age over 65 or with chronic health problems, otherwise optional</td>
</tr>
<tr>
<td>Last Pneumovax (pneumonia)</td>
<td></td>
<td>Recommended for age over 65 or with chronic health problems</td>
</tr>
<tr>
<td>Last Hepatitis B Vaccine</td>
<td></td>
<td>Required for school-aged children; optional for adults</td>
</tr>
<tr>
<td>Last Skin Test for TB</td>
<td>Was it positive or negative?</td>
<td>Recommended if exposed to persons at high risk for having tuberculosis</td>
</tr>
<tr>
<td>Last Measles Mumps Rubella (booster dose)</td>
<td></td>
<td>Recommended for women born after 1956 who plan on becoming pregnant</td>
</tr>
</tbody>
</table>

### Family History
Please indicate with a check any of the following medical problems within your family history:

- Y = Yourself
- M = Mother
- F = Father
- S/B = Sister or Brother
- GP = Grandparent
- A/U = Aunt or Uncle

<table>
<thead>
<tr>
<th>Medical Problem</th>
<th>Y</th>
<th>M</th>
<th>F</th>
<th>S/B</th>
<th>GP</th>
<th>A/U</th>
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<td>High Blood Pressure</td>
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### Social History

- Marital Status:  □ Single  □ Married  □ Widowed  □ Divorced  Number of children: ____________________________
- Occupation: ____________________________ Are you currently employed:  □ Yes  □ No
- Any occupational hazards (like noise or chemical exposures)?  □ Yes  □ No
  Describe: ____________________________________________________________________________________________
- Education (last grade completed in school): __________________________________________________________________________
- Do you have a religious affiliation?  □ Yes  □ No  (Optional) If yes, what is your affiliation? __________________________________________________________________________
- Have you ever been emotionally or physically abused by your partner or someone important to you?  □ Yes  □ No
- Have you ever been exploited, physically or financially, by someone important to you?  □ Yes  □ No
- Within the last year, have you been bit, slapped, kicked, pushed, shoved or otherwise physically hurt by your partner or ex-partner?
  □ No  □ Yes  If YES, by whom ____________________________ Number of times ____________
- Does your partner ever force you into sex?  □ Yes  □ No
- Are you afraid of your partner or ex-partner?  □ Yes  □ No
- Check any that you would like to discuss:  □ Alcohol/Drug use in home  □ Recent Death  □ Sexual Orientation
  □ Care of Aged/Ill Parent/Spouse  □ Care of Dependent/Grandchild
  □ Other Stress: __________________________________________________________________________________________
### Nutritional History

Has there been any change in your appetite in the past 6 months?  □ Yes  □ No

Have you gained or lost weight (more than 10 lbs) in 1 month without wanting to?  □ Yes  □ No

If yes, how much gain or loss? ____________________________

Are you happy with your weight?  □ Yes  □ No

If not, are you on a diet and exercise program?  □ Yes  □ No

For women: Are you taking any extra calcium?  □ Yes  □ No

### REVIEW OF SYSTEMS

Instructions: Check the box for each symptom that you have now or have had in the past three months. Fill in the blank spaces.

#### General:
- weakness
- fatigue
- chills
- night sweats
- change in weight, appetite or sleeping habits

#### Eyes:
- glasses or contacts
- blank spots in your field of vision
- excessive tearing or discharge
- eye pain
- double vision
- last eye exam, date: ________________

#### Ears, Nose, Sinuses, Mouth and Throat:
- loss or trouble hearing
- ringing
- frequent earaches
- nosebleed
- post nasal drip
- blockage of nose
- sinus pain
- sore throat
- hoarseness
- dentures
- bleeding gums
- toothache
- last dental exam, date: ________________

#### Lungs:
- cough
- shortness of breath
- wheezing
- spitting up blood
- positive TB test
- last chest X-ray, date: ________________

#### Heart:
- chest pain
- palpitations (heart pounding)
- trouble breathing at night
- fatigue easily with exercise
- ankle swelling

#### Skin:
- itching
- rash
- change in color
- changes in warts, moles, or birthmarks

#### Breast:
- lumps in breast
- discharge from nipple
- last mammogram, date: ________________

#### Gastrointestinal:
- vomiting
- difficulty swallowing
- stomach or abdominal pain
- indigestion or heartburn
- ulcers
- changes in bowel habits
- blood in stools (or black stools)
- hemorrhoids
- sigmoid or colonoscopy, date: ________________

#### Musculoskeletal:
- pain
- weakness
- twitching
- deformity
- chronic back pain
- joint swelling
- decreased range of motion

#### Vaginal and Urinary (female):
- vaginal itching or burning
- vaginal discharge
- sexually transmitted diseases (examples: herpes, syphilis, chlamydia, gonorrhea, AIDS, etc.)
- sexual difficulties
- last menstrual period, date: ________________
- problems with menstrual periods
- last pap smear, date: ________________
- methods of contraception: ________________
- pregnancy, number: ________________
- problems during pregnancy
- sexually transmitted diseases (examples: herpes, syphilis, chlamydia, gonorrhea, AIDS, etc.)
- previous urinary infections
- blood in urine
- kidney stones
- urine incontinence (leaking)

#### Genitals and Urinary (male):
- hernia
- discharge from penis
- pain or lump in testicles
- methods of contraception: ________________
- sexually transmitted diseases (examples: herpes, syphilis, chlamydia, gonorrhea, AIDS, etc.)
- previous urinary infections
- blood in urine
- kidney stones
- urine incontinence (leaking)

#### Hematologic and Lymphatic:
- easy bruising or bleeding problems
- swollen lymph nodes

#### Endocrine:
- excessively hot
- always thirsty
- excessively cold
- always hungry

#### Nervous System:
- headaches
- numbness
- head injury
- seizures
- dizziness or passing out
- loss of coordination or balance

#### Psychological:
- nervousness or anxiety
- depression
- unable to sleep
- nightmares
- memory loss
Habits and Safety
Are you very active, or get regular exercise?  □ Yes  □ No
Do you always wear your seatbelt when in a motor vehicle?  □ Yes  □ No
Do you have home smoke detectors AND check the batteries regularly?  □ Yes  □ No
If you are elderly or handicapped, do you feel your home is designed to prevent injuries?  □ Yes  □ No
Do you have problems with activities of daily living such as bathing, toileting or fixing meals?  □ Yes  □ No
If yes, explain: ____________________________________________________________
Do you currently smoke?  □ Yes  □ No  If so, how many packs a day ______ and for how many years? ________
If not, were you a former smoker?  □ Yes  □ No
Do you drink alcoholic beverages?  □ Yes  □ No  Amount per week:________________________
If you drink, have people ever criticized your drinking?  □ Yes  □ No
If you drink, have you ever felt bad or guilty about your drinking?  □ Yes  □ No
Have you ever used any recreational drugs (like marijuana, cocaine, heroin, intravenous drugs)?  □ Yes  □ No
Do you have any guns/weapons in the home?  □ Yes  □ No  If yes, can your children get to them?  □ Yes  □ No

Education Needs Assessment
Do you have any barriers to learning: □ None □ Vision □ Hearing □ Cannot Read □ Cannot Comprehend
□ Language/needs interpreter □ Other:______________________________________________
How does the patient best learn?  □ Pictures □ Reading □ Listening □ Demonstration □ Other:__________

Pain Screening
1. Do you have pain now?  □ No  □ Yes
2. Do you have any ongoing pain problems?  □ No  □ Yes  How long? ________________
If you answered yes to question 1 or 2 above, continue with questions 3-13.

3. Location: ________________________________________________________________
4. Intensity (0-10): Now __________  Usual __________
5. On a 0-10 scale, what is your level of pain when it is at its best? ________________
6. On a 0-10 scale, what is your level of pain when it is at its worst? ________________
7. On a 0-10 scale, at what level of pain are you able to function as you want? ________________
Key to scale 0 - 0 (check one):

□ 0  □ 1-2  □ 3-4  □ 5-6  □ 7-8  □ 9-10

8. Describe your pain (burning, aching, stabbing, dull, crushing):

9. What causes or increases your pain?

10. What symptoms are associated with your pain:
□ Altered sleep  □ Nausea  □ Appetite  □ Impaired concentration  □ Impaired mobility
□ Depressed  □ Irritable  □ Other: __________________

11. What do you do to relieve your pain?

12. What meds do you take for pain?

13. Are you satisfied with your pain control?  □ Yes  □ No

Signature of Patient/Person Filling Out Form ____________________________
Date ____________________________

PROVIDER USE ONLY

Provider Signature ____________________________
Date ____________________________
# NOVI INTERNAL MEDICINE AND PEDIATRICS, PLLC

## PATIENT REGISTRATION

(Please print information and give your insurance card and driver’s license to the receptionist so a copy can be made. Thank you.)

<table>
<thead>
<tr>
<th>Print Last Name:</th>
<th>First Name:</th>
<th>Middle:</th>
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<table>
<thead>
<tr>
<th>Address:</th>
<th>Zip:</th>
<th>City:</th>
<th>State:</th>
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</table>

<table>
<thead>
<tr>
<th>Home Phone:</th>
<th>Work Phone:</th>
<th>Cell Phone:</th>
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<table>
<thead>
<tr>
<th>Email:</th>
<th>Social Security #:</th>
<th>Date of Birth:</th>
<th>Sex: ☐ M ☐ F</th>
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<table>
<thead>
<tr>
<th>Employment Status:</th>
<th>☐ Full-Time</th>
<th>☐ Part-Time</th>
<th>☐ Retired</th>
<th>☐ Self-Employed</th>
<th>☐ Unemployed</th>
<th>☐ Student</th>
</tr>
</thead>
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<thead>
<tr>
<th>Marital Status:</th>
<th>☐ Single</th>
<th>☐ Married</th>
<th>☐ Divorced</th>
<th>☐ Separated</th>
<th>☐ Widowed</th>
</tr>
</thead>
</table>

Do you have any Medication Allergies? Please list___________________________________________________________

<table>
<thead>
<tr>
<th>Emergency Contact: (other than parent/spouse)</th>
<th>Relationship To You:</th>
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<table>
<thead>
<tr>
<th>Home Phone Number:</th>
<th>Pager/Cell Phone:</th>
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</thead>
</table>

**How did you hear about our practice?**

☐ Beaumont  ☐ Advertising  ☐ Insurance  ☐ www.novidocs.com  ☐ Welcome Wagon  ☐ Other: ______________________

**Heard about us through a Family Member, Friend or other Physician?**
We would like to thank them. Please print their name:_________________________________

## Person who should receive bill (guarantor or responsible party)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship To Patient:</th>
<th>Sex: ☐ M ☐ F</th>
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</thead>
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<table>
<thead>
<tr>
<th>Address:</th>
<th>Zip:</th>
<th>City:</th>
<th>State:</th>
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<table>
<thead>
<tr>
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<th>Work Phone:</th>
<th>Email:</th>
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<table>
<thead>
<tr>
<th>Cell Phone:</th>
<th>Social Security #:</th>
<th>Date of Birth:</th>
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<table>
<thead>
<tr>
<th>Employer:</th>
<th>Address:</th>
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<table>
<thead>
<tr>
<th>Employment Status of guarantor or responsible party:</th>
<th>☐ Full-Time</th>
<th>☐ Part-Time</th>
<th>☐ Retired</th>
<th>☐ Self-Employed</th>
<th>☐ Unemployed</th>
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</table>

### PRIMARY INSURANCE

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<tr>
<th>Social Security #:</th>
<th>Co-Pay:</th>
<th>Policy:</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Ins. Name:</th>
<th>Ins. Address:</th>
<th>Ins. Phone:</th>
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<tr>
<th>Group #:</th>
<th>Group Name:</th>
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<table>
<thead>
<tr>
<th>Subscriber Full Name:</th>
<th>Date of Birth:</th>
<th>Relationship to Patient:</th>
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### SECONDARY INSURANCE

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<tr>
<th>Social Security #:</th>
<th>Co-Pay:</th>
<th>Policy:</th>
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<tr>
<th>Ins. Name:</th>
<th>Ins. Address:</th>
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<tr>
<th>Group #:</th>
<th>Group Name:</th>
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<table>
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<th>Relationship to Patient:</th>
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### TERTIARY INSURANCE

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<th>Policy:</th>
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<tr>
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<th>Group Name:</th>
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<table>
<thead>
<tr>
<th>Subscriber Full Name:</th>
<th>Date of Birth:</th>
<th>Relationship to Patient:</th>
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Appt. Date: ____________
Novi Internal Medicine and Pediatrics, A Division of Envision Medical Group

Financial Policy

Dear Patients:
We are providing this for your review and acknowledgement. Please sign below where indicated.

Insurance: We participate in most insurance plans, including Medicare. You are responsible for ensuring our office has the most up to date insurance information. If we are not supplied with his information with 1 month of your visit, you may be responsible for the balance. Please make sure you know your co-pay and deductible, and what is covered by your insurance carrier. Contact your insurance carrier with any questions you may have regarding your coverage.

Cash Paying Patients: Patients without insurance will be asked to make an initial payment prior to being seen. New patients will be asked to make a payment of $140.00 (99203) prior to being seen; established patients will be asked to make a payment of $90.00 (99213). Once seen and services are rendered, the balance of payment due for the date of service is expected to be paid prior to leaving the office.

Credit Card Authorization/Payments: In recognition of the impact of the Affordable Care Act, we are requesting separate signed authorization to hold your credit card data via a random alphanumeric token on a secure gateway server in order to charge any outstanding balance over 30 days old.

Copays and Deductibles: Co-pays are a pre-set fee set by your insurance company, and should be paid at the time of service. Some insurance policies have a deductible that starts over at the beginning of every year, including Medicare. The deductible is the cost you must pay for medical treatment before your health insurance starts to pay. There may be a $10 charge for non-payment of your co-pay at time of service.

Non-Covered services: Please be aware that some of the services you receive may not be covered under your health insurance plan, or considered medically necessary by Medicare or other insurance carriers. These services should be paid at the time of services. For example, if you insurance company does not cover vaccines, then the cost of the vaccine should be paid at time of service.

BCBS Master Medical claims: Patients with Master Medical are responsible for payment at the time of their visit. As a courtesy, we will submit these claims to BCBSM. They will reimburse you directly.

Collections: If your balance remains unpaid after 90 days, your account may be referred to an external collection agency. As a result, you, or your immediate family, may be terminated from our practice for nonpayment.

Bounced checks: There will be a $35 charge for any bounced checks.

Missed appointments: There may be a $35 charge for missed appointments.

Appointments Cancelled without a 24-hour notice: Please be courteous, other patients may need your appointment time. Canceling your appointment without giving the office enough notice may result in a $20.00 charge.

Copy of records: There may be a fee assessed for copying of records requested for personal use or other providers. Record copying fees are charged in accordance with Michigan legal recommendations.

Attending Physician Statements (APS): There may be a charge of $95; either payable by you or your insurance carrier, for completion of attending physician statements.

We accept the following for payment: Cash, Check, Money Order, Visa, MasterCard, Discover, and American Express.

Thank you for understanding our financial policy. Please let us know if you have any questions.

_____________________________________________   _____________________
Signature of Patient or Responsible Party     Date

Patient Name
CREDIT CARD AUTHORIZATION FORM

Dear _____________________________,     Date: ______________________________

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card to pay your bill. This is an advantage for everyone because it makes checkout easier and faster, and more efficient.

We are implementing a similar policy. You will be asked for a credit card number at the time you check in and the information will be held in strict confidence. Once we are notified how much you are responsible after your insurance(s) has paid its portion for your treatment, any remaining balance you owe will be charged to your credit card and a copy of the charge will be mailed to your address.

Additionally, in the event you are delinquent in timely paying an overdue balance, we reserve the right to charge that amount on your credit card as well. We also request that you provide us with updated credit card information anytime that is warranted (card expires, etc.)

Handling small balances in this manner is advantageous to you because it will eliminate the necessity to write out (small) check(s). It will also decrease the number of billing statements that we have to generate and mail to you, decreasing our costs.

This in no way will compromise your ability to dispute a charge or question your insurance company’s payment determination. Co-pays remain due at the time of the visit. If you have a question for us, you may call our office.

I accept and agree that Novi Internal Medicine and Pediatrics, A Division of Envision Medical Group, PLLC can charge outstanding balances on my account to the credit card below. I acknowledge that I have had an opportunity to ask questions about this process.

Sincerely,

Novi Internal Medicine and Pediatrics, A Division of Envision Medical Group, PLLC

____ I wish to use my credit card to pay all unpaid balances on myself.
____ I wish to use my credit card on file to pay all unpaid balances for spouse and/or dependants (circle one or more)
____ I wish to use my credit card for overdue charges only.

Circle Credit Card Type:      Amex     MasterCard     Visa

Accountant#: _______Hand Credit Card to Receptionist_______ Expiration Date: ____________

Name on Card (please print): _________________________________________________________

Signature of Cardholder: ____________________________________ Date: ___________________

____ I wish to use my credit card to pay unpaid balances on myself or another family member.

____ I do not want to have my credit card on file. I understand that if I do not pay uncovered services, we reserve the right to send your outstanding balance to a collection agency. ________ Patient Initials

OFFICE USE ONLY:

CRT and EXTERNAL ID NUMBERS
FAMILY MEMBERS NAME & ID NUMBERS

TOKENIZATION #
NOTICE OF PRIVACY PRACTICES

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 _________ 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 healthcare 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.

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. billing 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 licensed staff shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If our licensed staff is required by law to treat you and 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 licensed staff attempts to obtain consent from you but is unable to do so due to substantial communication barriers and our licensed staff 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 or make disclosures that would constitute a sale of PHI 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).

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.____ for each page and $____ 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 disclosure made by us regardless of purpose.

Breach Notification: You have the right to be notified in the event of a breach of your unsecured PHI in the event one occurs, which such notification will be made directly to you or by alternative means as permitted by applicable law and regulations.

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 healthcare 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 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: ____________________________________________________________

Telephone: __________________ Fax: ____________________________________________

E-mail: ________________________________________________________________

Address: ________________________________________________________________
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient name: ______________________________________________________

Patient Signature____________________________________________________

Date: ______________________________________________________________

Documentation of Failure to Obtain Signed Acknowledgement

On _____________, 20__, _________________________________ presented this Acknowledgment of Receipt of Notice of Privacy Practices Form to:

___________________________________________________________, the Patient.

The Patient refused to provide a signature when requested:

_____________________________________    _________________
(Witness)                              (Date)
As required by HIPAA (Health Information Portability and Accountability Act) you have a right to nominate one or more persons to act on your behalf of receiving information with respect to your health information that pertains to you. By completing this form you are informing us of your wish to designate the name or names of individuals and telephone numbers where we can leave detailed information about your health care concerns. These individuals can be your spouse, family member or friend. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form.

**Authorization Section**

I designate the following person(s) to receive information about my health care and act as my personal representative with the use and/or disclosure of health information pertaining to me.

1) ____________________________________________  ______________________________
   Print Last Name   First Name   Telephone Number   Other Telephone

2) ____________________________________________  ______________________________
   Print Last Name   First Name   Telephone Number   Other Telephone

The authority of this/these person(s) when acting as my personal representative is restricted to the following functions: ____________________________________________

I understand that I may revoke this designation at any time by signing the revocation section of my copy.

Signature ________________________________ Date ____________

**Revocation Section**

I hereby revoke this designation of a personal representative.

Signature ________________________________ Date ____________

**Authorization to Leave Messages on Voice Mail/Machines**

I acknowledge that it is my right to refuse detailed messages from my physician or physician’s office staff regarding my medical care are left on my voice mail and/or answering machine. This authorization can only be revoked in writing.

☐ Yes, please leave me a message     Alternate Phone Number     Date ____________

☐ No, don’t leave any specific messages     Date ____________
When Your Child Needs To See The Doctor, But You Cannot Be There

Anytime you cannot come to the doctor’s office with your child, be sure you send the child to the doctor’s office with an adult (19 years and older), and give that adult written permission to get treatment for your child.

By law, a doctor cannot treat a child, except in life or death situations, unless the parent or guardian gives consent. Your child’s care, or immunizations, could be needlessly delayed because you cannot get to the office. Therefore, if you cannot come to the office with your child, make sure that the adult that brings your child to the office can make medical decisions for your child.

Your child might have a croupy cough and fever. The doctor might want to run a blood test and your child might need a shot. If you are not there, and the adult who brings your child does not have your permission to allow the doctor to run the test or get the shot, your child’s treatment will be delayed. You can avoid this by making sure that the adult caregiver has the proper written consent to make medical decisions for your child. You may revoke this designation at any time by signing and dating the revocation of your copy of this form.

Outpatient Treatment Permit/Authorization

1) __________________________________________

Print Last Name First Name Middle Initial Date of Birth

The undersigned does hereby grant to the individuals listed below (name of two adult individuals who will be responsible for the care of your child or children in your absence) the limited Power of Attorney to act for me and to give the required consents and authorizations for delivery of medical care, diagnoses and treatment, if necessary from ______________________ (today’s date) and to do all other necessary things as I might or could do if personally present, to include but not limited to:

- Health maintenance visits (routine and immunizations)
- Acute illness (outpatient care and treatment)
- Routine office procedures (x-rays, blood tests, etc.)

A) __________________________________________

Name of Responsible Adult Phone Number

B) __________________________________________

Name of Responsible Adult Phone Number

_____________________________________________
Signature of Parent or Legal Guardian Relationship to Child/ren

_____________________________________________
Address, City, State, Zip Code Telephone Number

Witnessed by Employee of Novi Internal Medicine and Pediatrics, PLLC, Louis W. Schwartz, DO, PLLC Date

Revocation Section

I hereby revoke this designation of a personal representative.

_____________________________  __________________________
Signature Date
A Patient-Centered Medical Home is a Partnership Between the Patient and Their Physician

<table>
<thead>
<tr>
<th>Being a part of a Patient-Centered Medical Home, your doctor will:</th>
<th>By choosing to participate in a Patient-Centered Medical Home, I agree to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Work with you to improve your health</td>
<td>• Make sure my doctor knows my entire medical history</td>
</tr>
<tr>
<td>• Review your medications at every visit and discuss with you any</td>
<td>• Tell my doctor all of the medications I am taking</td>
</tr>
<tr>
<td>interactions or contraindications</td>
<td>• Actively participate with my doctor in planning my care</td>
</tr>
<tr>
<td>• Electronically prescribe your medications to ensure they are</td>
<td>• Keep my appointments as scheduled</td>
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<tr>
<td>accurate and available to you promptly</td>
<td>• Adhere to the action plan designed by my doctors</td>
</tr>
<tr>
<td>• Develop a personal action plan with you to address your chronic</td>
<td>• Consult my doctor before making my own appointment with a Specialist</td>
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<tr>
<td>conditions</td>
<td>• Request that any other doctor I see send my doctor a report, copies of lab work, test results, and x-rays</td>
</tr>
<tr>
<td>• Set goals with you and monitor your progress</td>
<td>• Know my insurance and what it covers</td>
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<tr>
<td>• Use computer technology to monitor your progress and determine</td>
<td>• Provide the office feedback on how they can improve</td>
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<tr>
<td>if your health is improving</td>
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<tr>
<td>• Inform you of all test results</td>
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<tr>
<td>• Help you take control of your health by providing you educational</td>
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<tr>
<td>material, hosting group visits and linking you to other community</td>
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<tr>
<td>programs and resources</td>
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<tr>
<td>• Provide you 24 hour access to a clinical decision-maker by phone</td>
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<tr>
<td>• Have arrangements with after-hours care to be informed of your</td>
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<tr>
<td>visit or emergent treatment within 24 hours or next business day</td>
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<tr>
<td>• Reserve space in our schedule for you to accommodate a same-day</td>
<td></td>
</tr>
<tr>
<td>appointment</td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Patient-Centered Medical Home:</th>
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<tr>
<td>Signature:</td>
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