PiiM Partners In Internal Medicine

Welcome to our Practice:

We are pleased you have chosen Partners In Internal Medicine to be your primary care provider. We have practice information as well as the necessary forms you will need to complete prior to your appointment. You can also visit our webpage at **www.piim.org** for more information about our practice, physicians, access to health forms, and important health information.

Patient Forms:

- In order to provide more efficient service during your visit, we ask that you complete two (2) patient forms prior to your appointment.
- The first is a Patient history Questionnaire which will provide us with your complete medical history.
- The second form is our company's Financial Policy & Patient Responsibility Notice, which explains payment expectations and obligations, as well as payment options. It also outlines additional practice related fees.

Patient Reminders:

- We ask that you please arrive 10-15 minutes prior to your scheduled appointment. The Patient Registration process is performed upon your arrival to the office and prior to your scheduled doctor's appointment.
- We ask that you bring your current health insurance information in order to ensure accurate and appropriate billing of your health care services.
- If your visit is related to an auto accident or worker's comp injury, please be prepared to supply all relevant information so we may bill your claims correctly.
- We need for you to bring your current Photo ID.
- We also ask that you bring any medications you are currently taking in their original containers.

Practice Information:

We are committed to providing personalized patient care and strive to fulfill our promise to serve our patients health care needs. We are a Patient Centered Medical Home practice. This is a model of care that is patient centered and team based with emphasis on your well being. We will provide more information at the time of your visit. You may also visit our website which provides detailed information.

For your convenience, we have listed on our website participating insurance carriers. If you are not covered by one of these insurances, please refer to our financial policy. If you need to set up payment arrangements, please contact our Billing Service Representatives at (734)-994-7446.

If you have additional questions about the practice or its policies, please feel free to contact either office directly.

Thank you for choosing Partners in Internal Medicine.

Your Health Care Partners
PIIM

Welcome to Partners in Internal Medicine

Your Patient Centered Medical Home

A Patient-Centered Medical Home (PCMH) is a trusting partnership between a doctor led health care team and an informed patient.

We trust you, our patient to:

- Know that you are a full partner with us in your care.
- Tell us what you know about your health and illnesses. Follow the care plan that you and your care team have agreed is important for your health, or let us know why you cannot so that we can try to help.
- Tell us the medications you are taking, including over the counter remedies, and ask for refills at your visit when needed.
- Let us know when you see other doctors and what medications they prescribe or change.
- Seek our advice before you see other physicians. We may be able to care for you and we know about the strengths of various specialists.
- Keep your appointments as scheduled, or call and let us know when you cannot.
- Learn about your insurance so you know what it covers.

As your primary care provider, I will:

- Be available to you 24 hours a day 7 days a week. You can communicate with me by phone, email or the patient portal.
- Provide you with a care team who will know you and your health history.
- Take care of acute illness, long term disease and give advice to help you stay healthy.
- Help you understand your condition and how to care for yourself. I will help you sort through your options and decide what care is best for you, understanding that sometimes more care is not better care.
- Help you coordinate your health care by recommending specialists, making appointments and sending pertinent information to them.

Urgent Care:
We strive to accommodate patients who need care urgently. Please call us to see if we can accommodate you at our office. For evenings and weekends, please call the office number and our answering service will have a physician call you to discuss your condition. The doctor may recommend an Urgent Care Facility or an Emergency Room at a hospital, depending on the severity of your condition.

Test Results:
Test results are available on the Patient Portal once your physician has reviewed them. If you are not signed up for the Patient Portal, a copy of the result will be mailed to you. If your result is not showing on the Patient Portal or you have not received a copy within 14 days, please call the office for your results.

Available Community Services:
For referrals for help with human health, and social needs (i.e., home care, respite care, meals, transportation, housing, utilities)

Washtenaw County: Area Agency on Aging
800-852-7795

Wayne County: Dial 2-1-1 from any phone and you will be connected with a referral hotline.

Practice Hours
Monday, Tuesday, Thursday, Friday: 8:00am-5:00pm
Wednesday: 9:00am-5:00pm
Saturday & Sunday: Closed

Martha Gray, MD
Peter Paul, MD
Eric Straka, MD
Elissa Gaies, MD
Mark Oberdoerster, MD
Sara Hashemian, MD
Pam Shore, MD
David Weidendorf, MD

Ann Arbor Office:
2200 Green Rd. Ste B
Ann Arbor, MI 48105
P-734-994-7446
F-734-623-8591

Canton Office:
255 N. Lilley Rd.
Canton, MI 48187
P-734-981-3300
F-734-981-0653

Partners In Internal Medicine

2200 Green Rd
Ann Arbor, MI
48105
734 994-7446

255 N. Lilley Rd
Canton, MI
48187
734 981-3300

Dear Patient,

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, including lab and diagnostic test results, educational information, billing statements, and other health information.

Through the Patient Portal, you are able to:

- ask questions of doctors, nurses, and staff members
- request prescription refills and referrals
- request appointments
- view your personal health record (Records available on the Portal, are dated Oct 2011 forward. For records prior to Oct 2011, please contact the office.)
- examine your current and past billing statements

By using the Patient Portal, you no longer have to call the office, leave a message, and wait for a response to get the results of your lab work; those results will be available to you through the Portal. You can also send a message to the office through the Portal and expect a prompt reply.

To learn more or to register, contact our office today in Ann Arbor, 734 994-7446, or Canton, 734 981-3300. Our website, www.piim.org, has a link to the portal.

When our staff registers you, you will be given your login and temporary password. When you log into the Portal for the first time, you will be asked to choose a permanent password. You will also be asked to read and consent to the terms of use. Messages from our office will be in the "Inbox". To reply, you will need to send a "New Message". Portal messages are for general questions. If you are experiencing symptoms, please call the office.

Yours truly,

Your Health Partners at Partners in Internal Medicine

Partners in Internal Medicine
Financial Policy & Patient Responsibility Notice

We consider payment of services to be the responsibility of the patient in the patient-physician relationship. Therefore, we would like to explain our payment policy and patient responsibility expectations to ensure your understanding and compliance. First and foremost, it is expected that you provide our office with the most up to date information about you (contact info, insurance coverage, etc.) at every single visit. Partners in Internal Medicine (PIIM), provides many types of medical services within our practice. There are many insurance companies (each offering several different plans or policies) so we at PIIM cannot know whether a specific service is covered by a particular plan or policy. Stated otherwise, it is impossible for PIIM to know the different group benefits from one employer or individual plan to the next. Our staff will make every effort to assist you in understanding your health benefits, although we are not responsible for knowing/informing you what services are covered by your particular health plan.

For the insurance carriers we do participate with, we will file on your behalf directly for payment. Please see www.piim.org for the list of contracted insurances, or ask a member of our staff. **Insurance co-payments and non-covered services are expected to be paid in full at the time of service. PIIM accepts checks and all major credit cards.** Additional amounts may be due at a later date, after we have billed your participating insurance (i.e. coinsurance, deductible, uncovered services).

If you are covered by a **commercial insurance plan** that we do not participate with, you are expected to make full payment at the time of service/treatment. Upon receipt of full payment, as a courtesy we will submit your claim to your insurance carrier and a refund will be mailed to you for any reimbursement we may receive from the insurance company. If you are unable to make payment in full, we will be unable to provide this courtesy to you. If you have no insurance coverage, payment in full is expected at the time of your visit.

NEW FOR 2014 (Affordable Care Act):
If we are unable to verify eligibility with your insurance company for any reason (i.e. non-payment of marketplace premium), you will be expected to pay for all services in full the day of your visit. We will attempt to bill the insurance and a refund will be mailed to you for any reimbursement we may receive from the insurance company.

Consequences for non-payment/defaulting on payment of amounts due to PIIM:
1. Failure to pay copay, deductible, or other fee due at time of service = $20.00 additional processing fee (see description of fee below)
2. Unpaid balance after 3 statements mailed to you = balance forward to pre-collections for additional collection communications (TransWorld Systems Inc.)
3. Unpaid balance after additional 70 days = balance referred for complete collections (i.e. credit agency reporting) with TransWorld Systems, Inc. Accounts deemed delinquent are subject to collection costs and possible dismissal from our practice.

Additional Practice Related Fees:

- **$50.00 Fee** = "NO SHOWS" (failure to provide cancellation notice) prior to your scheduled appointment.
- **$35.00 Fee** = Returned checks for non-sufficient funds. We will not accept any personal checks until account balance and associated services fees are paid in full. If this is a repeated occurrence, we will only accept cash or credit card as method of payment.
- **$20.00 Fee (NEW)** = Time of Service/Processing Fee: Additional fee for failure to pay your copay, deductible, or other amount due on the date of your visit.

By signing below, I acknowledge and understand the Financial Policy of Partners in Internal Medicine, I agree to the terms of payment due, and accept all payment terms under this Policy. I understand my responsibilities as a patient to know and understand my health insurance benefits for services provided and agree to pay all applicable charges which are not paid in full by my insurance.

_____ _____
Signature of Patient or Person Responsible for Account Date

_____ _____
Office Staff – Witness Date

Partners In Internal Medicine

NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed, or how you can get access to this information. Please review it carefully.

EFFECTIVE DATE OF NOTICE: APRIL 14, 2003
Revision Date: September 23, 2013

Our Responsibilities

Partners In Internal Medicine takes the privacy of your health information seriously and is committed to protecting your medical information. We are required by law to maintain the privacy of protected health information, to provide you with this Notice of Privacy Practices, and to notify affected individuals following a breach of unsecured protected health information. This Notice describes how we use and disclose your health information and what rights you have regarding your medical information.

How we may use and disclose your health information:
Partners In Internal Medicine collects health information about you and stores it in an electronic chart. This is your medical record. The medical record is the property of this practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

- **TREATMENT.** We may use health information about you to provide your medical care. We may disclose your health information to doctors, nurses, or employees of Partners In Internal Medicine who are involved in taking care of you. Additionally, we may use or disclose your health information with other physicians or health care providers who will provide services that we don't provide. We may also disclose information to members of your family or others who can help you when you are sick or injured, or after you die.

- **PAYMENT.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations. We may use and disclose your health information for health care operations. These uses and disclosures are necessary to run our office and to make sure you receive competent, quality health care, as well as maintain and improve the quality of health care we provide. For example, we may use medical information to review our treatment and services in addition to evaluating the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. Other examples of how we may use or disclose your health information for health care operations are: financial, billing audits, internal quality assurance, personnel decisions, participation in manage care plans, defense of legal matters, business planning and outsider storage of our records. We may also disclose information to doctors, nurses, technicians, and other office personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of specific patients. We will also disclose your health information when required others may use it to study health care and health care delivery without learning the identity of specific patients. We will also disclose your health information when required to do so by federal, state or local law.
Sign In Sheet. We may call out your name when we are ready to see you by having you sign in when you arrive at the office.

- **For Public Health Purposes.** We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child, elder or dependent adult abuse or neglect, reporting domestic violence, reporting to the FDA medication problems, and reporting disease or infection exposure.

- **Other Uses such as:**
  - Appointment Reminders
  - Health Oversight Activities
  - Judicial Purposes/Subpoena
  - Law Enforcement
  - Coroners, Medical Examiners & Funeral Directors
  - Organ & Tissue Donation
  - Military & Veterans
  - National Security and Intelligence Activities
  - Custodial Situations
  - Worker's Compensation
  - Treatment Alternatives
  - Individuals involved in your care or payment of your care
  - Breach Notification

When Partners In Internal Medicine May Not use or Disclose Your Health Information. Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization at any time.

Your Rights Regarding Your Health Information:

- **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information by written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any request, and will notify you of our decision.

continued on the back

- **Right to Request Confidential Communications.** We communicate with you your regarding your health care either through your home phone, work phone, cell phone, email, or through the mail at your home address. You have the right to request that we communicate with you in a specific way. We will accommodate all **reasonable** requests submitted in writing which specify how or where you wish to be contacted.

- **Right to Inspect and Copy.** You have the right to inspect and copy health information with limited expectations. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee for labor, mailing or other supplies associated with your request. However, there is no charge for requests that involves forwarding your records to another physician office directly. We may deny your request under limited circumstances. If we deny your request because we believe allowing access would be reasonably likely to cause substantial harm, you will have the right to appeal.

- **Right to Amend.** You have the right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. We may deny your request if we do not have the information, if we did not create the information (unless the person that created the information is no longer available to make the amendment), or if the information is accurate and complete as is. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

- **Right to an Accounting of Disclosure.** You have the right to receive an accounting of disclosures of your health information made by Partners in Internal Medicine, except that this medical practice does not have to account for the disclosures provided to you with your written authorization, or as described in this notice for treatment, payment, health care operations, public health, or law enforcement officials.

- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. You may also obtain copy of this Notice at our web Site at www.piim.org.

- **Changes to this Notice.** By law, we must abide by the terms of the Notice of Privacy Practices. We reserve the right to amend this Notice. We reserve the right to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. We post a copy of the current Notice in a clear and prominent location to which you have access in our office. This Notice is also available upon request and is also posted on our website. The Notice will contain, on the first page, the effective date. In addition, if we revise the Notice and you are still with the Partners in Internal Medicine, we will offer you a copy of the current Notice in effect.

- **Complaints.** Complaints about this Notice of Privacy or how Partners in Internal Medicine handles your health information should be directed to our Privacy Officer listed below.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:
DHHS Region V - Chicago (Illinois, Indiana, Michigan, Minnesota,Ohio,Wisconsin)
CelesteDavis,RegionalManager
OfficeforCivilRights U.S. Department of Health and Human Services 233N.MichiganAve.,Suite240
Chicago,IL60601
VoicePhone(800)368-1019
FAX(312)886-1807
TDD (800) 537-7697

The complaint form can be found at:
www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf
You will not be penalized in any way for filing a complaint.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact:

Partners in Internal Medicine
Attn. Privacy Officer/Practice Manager
2200 Green Rd., Ste B
Ann Arbor, MI 48105
(734) 994-7446
(734 623-8590 fax

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

1. By signing below, I acknowledge that I have received Partners in Internal Medicine Notice of Privacy Practices ("Notice").

_____ _____

Signature (Patient or Authorized Representative) Date

_____

Printed (Patient or Authorized Representative)

2. Patient was unable to sign acknowledgment for one of the following reasons:

____ Patient Refusal

____ Patient Disability

____ Other: _____

_____ _____

Witness Date Date

PiM Partners In Internal Medicine

Patient Name: _____

Patient DOB: _____

I, _____ give _____
(Patient name) **(Person who may receive information)**

permission to inquire and receive information contained in my medical record at Partners in Internal Medicine. In addition, the above named person may inquire and receive information from the staff at Partners in Internal Medicine in regards to my presence in the office, any test results, any testing or physician visits ordered by my primary care physician, and/or dates of treatment.

Partners in Internal Medicine will give the information only to the person named above (with the exception of medical use by physician and clinical staff) and will not be held liable for doing so.

This authorization remains valid unless revoked by me in writing.

Patient Signature: _____

Witness: _____

Date: _____

PARTNERS IN INTERNAL MEDICINE

2200 Green Rd, Ste B
Ann Arbor, MI 48105
Phone: (734) 994-7446 Fax: (734) 623-8591

255 North Lilley Rd
Canton, MI 48187
Phone: (734) 981-3300 Fax: (734) 981-0653

Medical Release of Protected Health Information

Patient Name:_____ DOB:_____

Daytime Phone Number:_____

I hereby authorize the professional office of _____ to release **ALL** health information identifying me (including if applicable, information about HIV/AIDS, substance abuse treatment including mental health services information) under the following terms:

Detailed description of any information **NOT** to be released:_____

Please include the **COMPLETE** address of where you would like your records sent to. Requests can not be processed without this information.

Send records **TO**: Partners in Internal Medicine

Address: 2200 Green Road, Suite B City: Ann Arbor State: MI

Zip Code: 48105 Phone Number: 734-623-8587

List Purpose: Continuity of Care
I.e. per request of individual/patient, Workman's Comp, Life Insurance Company, Transfer of Physician, Continuity of Care, Judicial Purposes

Expiration date for this release:_____

When your health information is disclosed as provided in this release, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes the possibility.

I have read and understand this form and I am signing it voluntarily. I authorize the disclosure of my health information as described in this form. I understand that I may revoke this request at anytime by notifying the office in writing and that it will be effective on the date received.
I also understand that there are fees associated with the release of my health information to persons other than health professionals. (I.e. Insurance companies, for patient's personal use, disability)

Patient Signature:_____ Date:_____

If you are signing as a personal representative of the patient, describe your relationship and the source of authority to sign this form:

Print Name:_____ Relationship to patient:_____

Source of Authority:_____

PiiM Partners In Internal Medicine

Patient History Form

FOR OFFICE USE ONLY
HEIGHT:
WEIGHT:

Name *(Last, First, M.I.):*	DOB:

IF YOU CAN READ THIS FORM, PLEASE SIGN HERE: _____

Date of last physical exam:	Occupation:

Any recent air travel (within 2 weeks)?	☐ Yes	☐ No

PERSONAL HEALTH HISTORY

List any ongoing/current medical conditions (i.e. Diabetes, thyroid, high blood pressure, acid reflux/GERD, etc.)

OTHER PROBLEMS

Check if you have/have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in weight
☐ Head/Neck	☐ Back	☐ Memory Issues
☐ Ears	☐ Stomach/Intestinal	☐ Mental Illness
☐ Nose	☐ Bladder	☐ Trouble sleeping
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Sexual Dysfunction	

Surgeries

Year	Reason	Hospital

Past Hospitalizations

Year	Reason	Hospital

MEDICATION LIST- prescribed drugs and over-the-counter drugs, including vitamins and inhalers (use back if space needed)

Name the Drug	Strength	Frequency

Allergies to medications

Name the Drug	Reaction You Had

MENTAL HEALTH

Do you feel down, depressed or hopeless?	☐ Yes	☐ No
Do you have trouble enjoying things that you used to enjoy?	☐ Yes	☐ No
Have you ever been to a counselor/therapist?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling(s)	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

HEALTH HABITS AND PERSONAL SAFETY

Exercise	How many days a week do you exercise?				
	What do you do for exercise?				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Pop/Soda	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes – pks./day: _____	☐ Chew/Pouches	☐ Vape/E-Cig	☐ Cigars	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
	Do you use Marijuana for a medical condition? – If yes, type/freq:			☐ Yes	☐ No
Safety	Have you had a fall this year? If yes, # of falls this year:			☐ Yes	☐ No
	Do you have vision or hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No
	Do you use a CPAP machine? If yes, date of last sleep study:			☐ Yes	☐ No
	Last Colonoscopy (Year or Date):				
	Date of Last Eye Exam:				
	Date of Last Dental Exam:				

WOMEN ONLY

Date of last menstruation:		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Date of last pap and rectal exam? Name of OB/GYN (if applicable):		
Date of last mammogram:		

REVIEWED BY:

_____MD DATE:_____